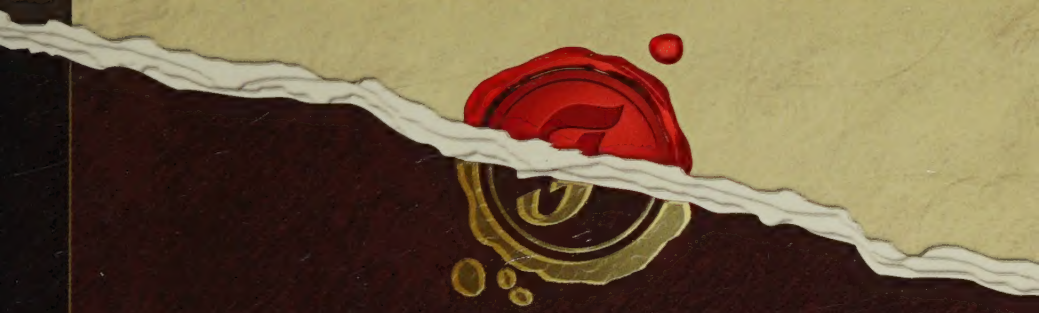
CLASSIC REPRINT SERIES

The Major Symptoms of Hysteria

Fifteen Lectures Given in the Medical School of Harvard University



by

Pierre Janet

Forgotten Books

Digitized by the Internet Archive
in 2026

https://archive.org/details/bwb_Y0-DCA-651

* 1,000,000 *

Free E-Books

@

www.ForgottenBooks.org

* Alchemy *

The Secret is Revealed

@

www.TheBookofAquarius.com

Forgotten Books

The Major Symptoms of Hysteria

By

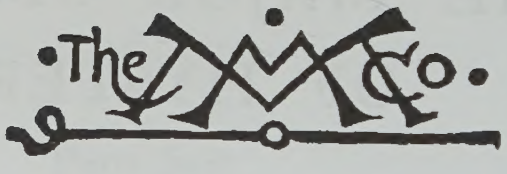
Pierre Janet

Published by Forgotten Books 2012
Originally Published 1907

PIBN 1000369166

Copyright © 2012 Forgotten Books
www.forgottenbooks.org

THE MAJOR SYMPTOMS OF HYSTERIA


The MMC Co.

THE MAJOR SYMPTOMS OF HYSTERIA

FIFTEEN LECTURES GIVEN IN THE MEDICAL SCHOOL OF HARVARD UNIVERSITY

BY

PIERRE JANET, M.D.

PROFESSOR OF PSYCHOLOGY IN THE COLLÈGE DE FRANCE
DIRECTOR OF THE PSYCHOLOGICAL LABORATORY IN
THE CLINIC OF THE SALPÊTRIERE

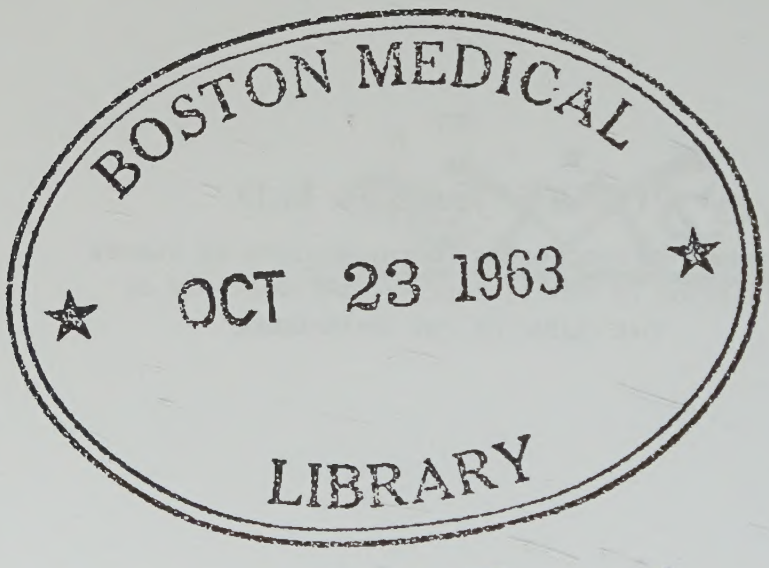
New York
THE MACMILLAN COMPANY
LONDON: MACMILLAN & CO., LTD.
1907

All rights reserved

Copyright, 1907,

By THE MACMILLAN COMPANY.

Set up and electrotyped. Published June, 1907.



19 F H H.

Norwood Press
J. S. Cushing & Co. — Berwick & Smith Co.
Norwood, Mass., U.S.A.

PROFESSOR JAMES JACKSON PUTNAM

OF HARVARD UNIVERSITY

THESE LECTURES ARE AFFECTIONATELY

DEDICATED

PREFATORY NOTE

On the occasion of the inauguration of the new and magnificent buildings of the Medical School of Harvard University in Boston, President Eliot and Dr. J. J. Putnam, professor of the diseases of the nervous system, asked me to deliver before the students some lectures about pathological psychology. I greatly appreciated this honour, and tried to sum up before the American students some elementary psychological researches about a well-known disease, Hysteria, in order to show them how the study of the mental state of the patient can sometimes be useful to explain many disturbances and to give some unity to apparently discordant symptoms. So the following fifteen lectures were given in the Harvard Medical School between the fifteenth of October and the end of November, 1906. Some of these lectures were also delivered in Johns Hopkins University at Baltimore, at the request of Professor J. M. Baldwin, and in the medical school of Columbia University in New York, at that of Professor Allen Starr. I avail myself of the opportunity of this publication to offer my best thanks to these professors and their colleagues for their invitation and hearty welcome. Let me, too, thank here my friend M. Edouard Philippi, for the very useful help he gave me in drawing up these lectures in a foreign language.

Boston, Massachusetts,
November 25, 1906.

CONTENTS

PAGE

PREFATORY NOTE vii

LECTURE I

THE PROBLEM OF HYSTERIA 1

LECTURE II

MONOIDEIC SOMNAMBULISMS 22

LECTURE III

FUGUES AND POLYIDEIC SOMNAMBULISMS . . . 44

LECTURE IV

DOUBLE PERSONALITIES 66

LECTURE V

CONVULSIVE ATTACKS, FITS OF SLEEP, ARTIFICIAL SOMNAMBULISMS 93

LECTURE VI

MOTOR AGITATIONS — CONTRACTURES 117

LECTURE VII

PARALYSES — DIAGNOSIS 138

LECTURE VIII

PAGE

The Psychological Conception of Paralyses and Anesthesias 159

LECTURE IX

The Troubles of Vision 182

LECTURE X

The Troubles of Speech 208

LECTURE XI

The Disturbances of Alimentation 227

LECTURE XII

The Tics of Respiration and Alimentation . . 245

LECTURE XIII

The Hysterical Stigmata — Suggestibility . . 270

LECTURE XIV

The Hysterical Stigmata — The Contraction of the Field of Consciousness — The Common Stigmata 293

LECTURE XV

General Definitions 317

Index 339

THE MAJOR SYMPTOMS OF HYSTERIA

THE MAJOR SYMPTOMS OF HYSTERIA

LECTURE I

THE PROBLEM OF HYSTERIA

The interest and importance of studying hysteria — The philosophical and the medical point of view — Brief account of the evolution of the studies about this disease — The necessity for the psychological study of the neuroses — The psychological type of hysteria

GENTLEMEN: President Eliot and the Professors of the great University of Harvard have determined to celebrate the opening of the new buildings of your Medical School by putting into practice a beautiful and great thought. They have determined to invite to come among them foreign professors, and have begged them to expose before you the ideas and teachings they give in other countries. It is a mode of teaching which is very often used in American universities but, unfortunately, is rarely applied in France. It may have the most beautiful results for the teaching of youth, for the development of science, and for the union of the various nations, which is in our time the great aim of all true civilizations. Unhappily the application of this beautiful method is very difficult, for all depends on the choice of that foreign professor

called momentarily to teach among you. No doubt I congratulate myself very much upon the choice which has been made; it is for me a great honour, it gives me an opportunity to see again a town of which I am very fond, and to try to diffuse among you some ideas to which I hold. But I dare not congratulate you upon this choice, for I am afraid my ignorance of your methods of teaching, and above all my ignorance of your tongue, will make these lectures very hard to understand and very painful to hear. First, I make you my apologies; then, I wish you may overcome this bad luck and forget as much as possible the incorrectness and strangeness of my language. This done, let us all do our best — you to understand me tolerably well and to draw from these lectures some notions of what interests French students; I, to speak nearly intelligible English and to give you as favourable an impression as possible of the psychological study of nervous diseases in the French universities.

I

With the approval of President Eliot and of Professor James J. Putnam, I have chosen as the subject of these lectures the study of that nervous and mental disease called Hysteria. The reason of this choice is that from many points of view this study seems to me pretty well to answer the wish of the professors who called me. When a foreign professor is asked to express his ideas in another country, he is expected to expose one of the most characteristic studies of his

native land, just as, when we have landed in a new country, we seek to taste the dishes that characterize its cookery. Well, it seems to me that what has been most characteristic in France for a score of years in the study of nervous diseases is the development of pathological psychology. No doubt, the clinic and anatomic study of these same diseases is very honourably represented by French names, but this study has developed in the same way in other countries, and I think you have not much for which to envy us in this matter. Psychological studies, properly so called, especially the studies of psychological measures, have developed in Germany and in America more than in France, and it is not here, near Professor Münsterberg's laboratory, that it would be well to come and deliver a lecture on this subject. But it seems to me that in France, under the influence of two of my masters, whose names I like to recall, — Charcot and Professor Ribot, — was realized an interesting union between two studies which were for the most part separated before. Beautiful natural experiences have been borrowed from mental pathology which strongly illuminate the problems of psychology; on the other hand, notions of experimental psychology have been made use of in order to understand and sometimes to treat patients' mental disturbances. I should be happy to make you feel how interesting is this new study, which seems to me to have very good prospects.

Among these studies of pathological psychology, I determined on taking that of a particular nervous disease, Hysteria; I think it is by this one that one

should begin nowadays; for this we have historical and scientific reasons. Look back to the time of the first works of Charcot, Ribot, and their pupils. Cast a glance at the innumerable works which, twenty years ago, determined that current of researches. Remember the names of Mesnet, Pitres, Paul Richer, Charles Richet, Binet, Fere, Marie, Grasset, Gilles de la Tourette, Brissaud, and in foreign countries, of Delbœuf, Moebius, Breuer, Freud, Morton Prince, etc. Remark what was, by a kind of singular common understanding, the subject of all their works. No doubt they seemed, like Professor Ribot, to speak of all possible mental diseases and to seek for mental disturbances in all the forms in which they present themselves. Now and then, it is true, they devoted a few lines to idiocy or insanity; but if you read their books again, you will see that, whatever the matter is, "Maladies de la Memoire," "Maladies de la Volonte," "Maladies de la Personnalite," they always speak of localized amnesias, of alternating memory, which in reality are only to be met among hysterical somnambulisms; of irresistible suggestions, hypnotic catalepsias, which are, as I will try to prove to you, nothing but hysterical phenomena; of total modifications of the personality divided into two successive or simultaneous persons, which is again the dissociation of consciousness in the hysteric. Besides all these works, pathologic psychology owes very much to the considerable movement concerning hypnotism, which took place during a few years. It is certain that the works of Charcot, Bernheim, Forel, and so many others

had the greatest influence on the development of this new science, but now that the quarrels of other times are somewhat appeased, everybody will probably recognize a fact which I hope also to be able to prove to you; namely, that in reality it is only among hysterical patients that this hypnotism is to be found in any marked degree. I will not raise now the difficult problem of deciding whether all the people who can be hypnotised must be called hystericals, but I believe almost every good observer will agree with me that the best studies about the clearest cases of artificially induced somnambulism and about its psychological properties were made on hysterical subjects. Consider even the somewhat adventurous authors who have sought to draw attention to particularly strange phenomena and who, by the curiosity they have raised, have had a share in the development of the same researches; remember the studies on psychic polarization, on transfer, on marked points suggestions (*suggestions a points de repere*), on unconscious acts, etc. These studies have always had for their starting-point hysteric phenomena as equivalences and anesthesias. In a word, if any interest is given to the development of that pathological psychology which has been growing these twenty years, it ought to be recognized that this interest has for its object a special disease: Hysteria.

No doubt, such exclusive fondness for this study was rather exaggerated, and all the psychologists who, for some time, in imitation of the masters, studied the hysteric, were somewhat like the sheep of our Panurge. It was an exaggeration to think that pathological psy-

chology could not be studied on other patients. Dr. Fere was somewhat mistaken when he called hystericals the frogs of experimental psychology. As in physiology the frog is not an absolutely necessary animal for our experiments, so the hysteric patient is not the only one worthy of psychological researches. We are even certain to-day that the hysteric offer many drawbacks, and many studies have been made on other diseases. However, it is true that there were certain practical reasons justifying this choice at the beginning of this kind of studies; and these practical reasons are still the same for you. The psychology of the hysteric patient, though full of difficulties and obscurities, is surely simple. It is a question of measure; all I want to say is that we are nowadays quite unable to understand, to express in formulas and in laws, what an insane person feels. We can hardly connect together by general laws the different facts observed in melancholic delirium or in the delirium of persecution. On the contrary, the various accidents of hysteria, though so different in appearance, are easily brought close to one another owing to common characters. We can dimly see some general laws, about the formula for which we hesitate, but of whose existence we have a suspicion. That is, after all, the reason that explains the character of the discussion about hysteria nowadays. While nobody endeavours to give or to discuss a general definition comprising all the phenomena of epilepsy or melancholia, there are now a great number of authors who propose to explain in a few words, in a single definition, all the pathology of hysteria. In short, I

was right in saying to you that the psychology of this disease seems now to be simpler than the conception of other mental diseases. It is the reason why I told you that the psychology of this disease is simple. To this primordial reason are added practical reasons: the hysteric are patients who are easily managed, who talk willingly, who are not dangerous, on whom we can experiment without any great fear, and who, lastly, like to be observed, and readily lend themselves to examination. Such are the reasons why the first studies were devoted to this kind of patients, and, in following the historical order, we also follow the practical order, which leads us to begin with the simplest and easiest disease.

II

Do not think, however, that this choice of the study of the hysteric is only justified by an historical chance and by reasons of convenience. The study of these patients, if happily it is a rather easy one, is at the same time very important, both from the philosophical and scientific and from the medical and practical point of view. I am convinced that in our times, every well-educated man wishing to have an opinion on moral and philosophical problems ought to know something of this singular mental disease, for it has played a considerable part in the history of all religions and superstitions, and it still plays a very important part in the most attractive moral questions. A great French alienist, Moreau de Tours, was in the habit of saying that all the great things accomplished in the world have been

accomplished by mad people. It is perhaps somewhat exaggerated, but it is nevertheless true that most great creeds have spread by means of the emotion caused by surprising phenomena, which have always been due to hysteric people. In the development of every great religion, both in ancient and in modern times, there have always been strange persons who raised the admiration of the crowd because their nature seemed to be different from human nature. Their manner of thinking was not the same as that of others; they also had extraordinary oblivions or remembrances, they had visions, they saw or heard what others could not see or hear. They were illumined by odd convictions; not only did they think but they also felt in another way than the bulk of mankind; they had an extraordinary delicacy of certain senses joined to extravagant insensibilities which enabled them to bear the most dreadful tortures with indifference or even with delight. Not only did they feel but they also lived otherwise than other people; they could do without sleep, or sleep for months together; they lived without eating or drinking, without satisfying their natural needs. Is it not such persons who have always excited the religious admiration of peoples, whether sibyls, prophets, pythonesses of Delphi or Ephesus, or saints of the Middle Ages, or ecstatics, or illuminates? Now they were considered as worthy of admiration and beatified, now they were called witches or demoniacs and burnt; but, at the bottom, they always caused astonishment and they played a great part in the development of dogmas and creeds.

Well, all these phenomena, as you know already, are the usual symptoms of hysteria, and there is not, from this point of view, a disease which has played so great a part in history. If I am not mistaken, it is still exactly the same now: we have changed only in appearance. We beatify but few saints and we burn but few demoniacs, yet we have not forgotten them; they have become our somnambulists and mediums, and every time we want to throw some light on the mysteries of our destiny, to penetrate into the unknown faculties of the human mind, to whom do we appeal? Whom do we take as a subject of observation? Is it an ordinary person, a person in good health, whom we ask to foresee the future or to talk with the dead? No; it is a neuropathic patient, insensible to the things of this world, but whose sensibility is overexcited in a certain direction; medically speaking, it is a hysteric person.

Understand me well. I do not mean at all to tell you that these studies are warped by this, any more than I deny the sanctity of a personage of the Middle Ages whom I diagnosticate as hysteric. A hysterical person may be a saint; a hysterical person may have a wonderful lucidity: that is undeniable. I only want you to be warned of what happens when you have to judge facts of this kind. When we have to appreciate facts which are out of our habitual observation and look wonderful, it is a material point to know well in what conditions they present themselves. Now in the question we are considering, one of these conditions, the most serious one, is the mental state of the persons in

whom such facts are observable. So you must know that such persons are hystericals, and be accustomed to the laws ruling the minds of hystericals. Perhaps there may be some cases in which this ascertainment does not diminish the interest taken in the phenomenon, but, believe me, it mostly takes away a great part of the wonderful. To judge these moral and philosophical problems, it is indispensable to study thoroughly this disease of the mind.

This remark is truer still if you consider the subject from a medical and practical point of view. You who have chosen the medical career and will have to attend patients belonging to every class of society: bear in mind that you will constantly meet with neuropathic phenomena connected with this group of neuroses and that you will commit the most dangerous mistakes if you are not very well accustomed to the aspects and evolution of hysteria. It was the fashion for a certain time to say that hysteria was a very rare disease; you know that it had a bad reputation, that a kind of dishonour was attached to this word, and that people tried to persuade themselves that this shameful disease was not of frequent occurrence. By a kind of international irony, people were willing to admit, after the innumerable studies made by French physicians, that hysteria was frequent only among French women, which astonished nobody, on account of their bad reputation. Do not believe this nonsense. American women are terribly like French women. I was not astonished therefore, when, two years ago, at the Chicago County Hospital and at the Boston City Hospital, some kind fellow-

physicians immediately showed me hysteric women, humorously adding that they were quite the same as those of La Salpetriere. The difference of races is also one of those silly things which the human mind has much difficulty in getting rid of. All civilized nations are now the same: we have the same mind and the same body, and, it must be recognized, the same miseries. If the hysterical seemed to be less numerous in other countries, it is first because physicians did not recognize them, then because they would not give them their real appellation. When medical instruction is more general in this matter, when prejudices have vanished, it will probably be acknowledged that in this matter, as in many others, the other nations have no reason for envying France.

So you will often meet with hysterical people. You will call them neurasthenic for the family, if you like. I don't care. I only wish that you should at least know what is the matter. You must be able quickly to recognize this disease, in order to foresee its evolution, to provide against its dangers, and immediately to begin a rational treatment. This early diagnosis is much more important still from another point of view: it will keep you, allow me to tell you plainly, from making blunders. It is perhaps not very serious not to recognize a hysterical accident and not to treat it; but what is always very serious is to mistake a hysterical accident for another one, and to treat it for what it is not. You cannot imagine the medical blunders, and too often also the medical crimes, committed in this way. One of the greatest difficulties in the medical art and one of

the greatest misfortunes of patients is that hysterical diseases are only well characterized from the moral point of view, which usually is not examined at all; that they are very badly characterized from the physical point of view, and that they are uncommonly similar to all kinds of medical or surgical affections, for which they are easily mistaken. Contractures, paralyses, anesthesias, various pains, especially when they are seated in the viscera, may simulate anything; and then you have the legion of false tuberculoses of the lungs, of false tumours of the stomach, of false intestinal obstructions, and above all, of false uterine and ovarian tumours. What happens as to the viscera also exists as to the limbs and the organs of the senses. Some hysterical disturbances are mistaken for lesions of the bones, of the rachis, for muscular or tendinous lesions. Then the physician interposes, frightens the family, agitates the patient to the utmost, and prescribes extraordinary diets, perturbing the life and exhausting the strength of the sick person. Finally, the surgeon is called in. Do not try to count the number of arms cut off, of muscles of the neck incised for cricks, of bones broken for mere cramps, of bellies cut open for phantom tumours, and especially of women made barren for pretended ovarian tumours. Humanity ought indeed to do homage to Charcot for having prevented a greater depopulation. These things no doubt have decreased, but they are still done every day. Not long ago I saw a patient who had had an eye excised and the optic nerve cut out for mere neuropathic pains. If I could only, by calling your attention and interest to the knowl-

edge of this disease, contribute to diminish the number of these medical crimes, I should already have attained a very important result.

III

In order to be able to enter upon the study of hysteria in a profitable way, allow me, before I end the introduction, to summarize in a few words the history of the studies which have been made on this disease. We are not isolated in our studies: we come after generations of other students, and we always ought, before we begin our own researches, to try to see our way exactly. We ought to see at what point of medical history we are standing, what has been done and well done before us, what we have not to begin again. We ought to realize the difficulties that stopped our predecessors, in order to add our efforts to theirs, and to make some steps forward in the way they have laid down for us. The history of these studies would be a very long one, for they began in the remotest antiquity: Democritus already has his theory about hysteria. But I think that we can summarize this long history in a few words by establishing a few great divisions, and I propose to you to adopt three great divisions. At first this history was anecdotical and descriptive: it is a period of curiosity and of somewhat uneasy and uncritical admiration. It is the period of sibyls, witches, convulsionists of all kinds, and of miscellanies of surprising facts about convulsions, somnambulisms, resurrections of lethargic people, extraordinary fastings, miraculous

wounds, etc. The second period, which, in reality, began very late, only in the nineteenth century, might be called the clinical period; then physicians sought, above all, to give a medical character to this disease, to distinguish it from other maladies, and to recognize the phenomena that appertain to it. It is a kind of clearing away and classification. The third period, which is quite contemporary, deserves to be called the psychological period; for, right or wrong, it is among mental phenomena that, for these thirty years, the interpretation has been sought of these innumerable phenomena which our first ancestors had only described and which their successors contented themselves with classifying. Later, perhaps, there will come an anatomical and physiological period, but, in my opinion, it does not yet exist.

A word only about each of these great stages. In the first, it is sufficient to remind you of the names of Plato, Hippocrates, Celsus, Galienus, Ætius, of the authors who, in the middle ages, described possessions, choreas, epidemics of tarentism. Among them are Ambroise Pare and Fernel. A little later we have to cite Charles Lepois, who gave in the seventeenth century one of the best descriptions; Sydenham, who made known the hysterical nail, coughing, vomiting, and œdema; Raulin (1758), who supported the opinion of Sydenham, and was one of the first to maintain that there were hysteric men; Witt (1767), Sauvage (1760), Astruc (1761), and Pomme (1760–1782), who discussed this strange problem. This descriptive period was, in fact, disturbed by a puerile and dangerous conception which vitiated all the

studies and made any attempt at an interpretation impossible. You know the old revery of Plato in the *Timæus:* "The matrix is an animal which longs to generate children. When it remains barren for a long time after puberty, it finds it difficult to bear, it feels wroth, it goes about the whole body, closing the issues for the air, stopping the respiration, putting the body into extreme dangers, and occasioning various diseases, until desire and love, bringing man and woman together, make a fruit and gather it as from a tree." This pretty little story was for half a score of centuries the only interpretation of hysteria, and still originated all the foolish ideas expressed by Louyer de Villermay in 1860. You may guess the part played in this respect by the abdominal pains seated at the level of ovaries, by the movements of the hysterical nail, by the suffocations of the patients during their fits. As hysteria required an uterus (*υστερον*), its existence was not admitted in men, and the first serious discussions bore on the existence of masculine hysteria.

The recognition of this disease in men changed the old conception of hysteria and determined an ensemble of more precise clinical researches. Without pretending to any chronological precision, we place at the beginning of the nineteenth century the inauguration of the second and truly clinical period. It is sufficient to remind you of the names of Georget (1821), of Hufeland in Germany (1836), of Brachet and of Landouzy in France (1845), of Duchenne de Boulogne (1855), of Legrand du Saulle (1860). But I must insist on the beautiful book of the English physician Brodie (1837),

who described the sensitive and motor disturbances in the articulations, and who has given his name to an hysterical accident, the knee of Brodie. We must accord a good place to the work of Briquet (1859); it was the first general work of real value and it prepared the way for the contemporary studies. Lastly, you know that the most eminent representative of that period is Charcot, who in every way gave more precision to the clinical knowledge of hysteria.

With these studies are connected the distinction between the epileptic and the hysterical fit, which was for a long time considered impossible; the diagnosis of apoplexies, cerebral lesions, meningites, of hysterical mutisms, and fits of sleep; the separation between hysterical anorexies, gastralgias, and dyspnæas, and the organic diseases which are apparently seated in the same viscera. It is chiefly to the patient studies of our predecessors that we owe the discovery and diagnosis of the different motor accidents of hysteria, of the articular disturbances analogous to the knee of Brodie, of the contractures, of the paralyses limited to one limb. Discussions relating to these motor accidents, their comparison with the diverse organic paralyses, researches on the traumatic neuroses, filled, as you know, the career of Charcot.

In all these studies there was no room yet for an interpretation of the disease, and Charcot felt thoroughly the necessity of an interpretation of this kind. It was indispensable, not only in order to explain things apparently mysterious, but chiefly to give a unity capable of linking together those innumerable symptoms that

looked so heterogeneous. Lasegue had already said that "manifestations apparently the most disorderly have not the individual character one supposes, and they are not inexplicable exceptions." "Nothing is left to chance," said Charcot; "on the contrary, all happens according to rules, always the same, common to private and hospital practice, applicable to all countries, to all times, to all races." He naturally sought to discover this determinism and these general laws of hysteria. Carried along by his habits as a clinician, he has, I think, sought these general laws too much in the physiological domain, which led him to a certain number of regrettable errors. In opposition to his school other studies, and in particular those of M. Bernheim in Nancy, have shown that this unity of hysteria, this interpretation of the symptoms it presents, would be much more surely found in the domain of the moral phenomena.

The contest of the two schools was the occasion of the development of psychological pathology, of which I have spoken to you, and brought on the beginning of the third period, the psychological period of the studies in hysteria.

This period, which has already lasted for about twenty years, is still difficult to judge. It seems to me, however, that its first clear results, though interesting, are still very incomplete, and that I ought to warn you against their attractive simplicity. A certain number of authors have been seduced by the psychological explanation. It seemed to them that the mere words "moral" and "thought" were enough to explain every-

thing, and, as people generally like simple explanations, physicians are too disposed nowadays to be content with a vaguely mental explanation. Hysteria, they say, is a psychic disease; it is the disease of suggestion, taken in a vague sense; it consists in disturbances which the patients persuade themselves that they have; it is the disease of persuasion. Many physicians think that, when they have expressed a few formulas of this kind, nothing remains to be said. There is some truth in this view, for it brings into relief the psychic character of the affection; but it is quite insufficient. We should, in my opinion, retain something of the precise method of Charcot, of the search after the determination and the laws of hysteria, and apply it only to the psychological fact, instead of always seeking for this determinism in physical facts. We must therefore use a certain preciseness in the description and study of the moral phenomena of hysteria.

The description of such a disease is very difficult, first because the symptoms are exceedingly numerous. You know that formerly Sydenham called it a Proteus, an ever-changing malady. But the description is also difficult because the disease is not clearly defined, because its limits, unfortunately, are very vague. It is easy to see that many contemporary authors do not quite agree about what they describe under the name of hysteria, and that some have a much broader conception of the disease than others. This indecision generally surprises young people. You think that, in science, things are perfectly definite, and you are very much astonished to find indecision in your masters. In

reality definiteness does not exist in natural phenomena; it exists but in our systematic descriptions. It is the men of science who cut separate pieces out of a whole that nature has made continuous. Do you believe that animal species are sharply distinguished from one another? Look at the quarrels of naturalists about the limits of the classes, about the animals of transition, which may at will be connected with one class or another. Remember the doctrine of evolution and the origin of species of Darwin. All this is still truer in regard to diseases, which, in reality, have not the distinctness we invent. Physicians, it is true, may agree in certain cases, when there is a distinctly visible objective phenomenon characterizing such or such a lesion—histologic analysis will serve to define a syphilitic lesion; in other cases, the presence of a microscopic organism will be a guiding mark, and the recognition of the bacillus of Koch will define a tuberculous lesion. But unfortunately we have nothing of the kind at our disposal to define the diseases of the mind. Save the case of general paralysis, there is no anatomical means to distinguish a patient labouring under the mania of persecution from the one who is affected with melancholia or neuropathy. When you have found the microbe of hysteria, you will be able to transform all my descriptions and to make them much more accurate.

Nowadays there is evidently a hypothetic, conventional part in the description and definition of a mental disease. Nobody, I think, felt so clearly the necessity of such hypotheses and conventions as Charcot when he exposed what he called the method of types. When

one wishes to describe a nervous disease, one must not fancy that one may comprise in its description all possible subjects. There are always some indistinct phenomena, some aberrant cases, some contradictory symptoms. In this case, if one tried to satisfy everybody, one would satisfy nobody; by seeking to be too true, one would be unintelligible. One must determine on making a necessary hypothesis, which characterizes the teaching and the opinion of a master; one must choose among the innumerable cases of the disease that which, in one's personal experience, appears to be the most important, that which presents the most definite phenomena, the most distinct from other maladies, the most frequent with patients of the same kind, the most intelligible. This patient becomes a type, which one describes by preference, though one knows very well that all the others are not absolutely like it, but because one supposes that they deserve the same name in the measure in which they resemble it.

This is what I shall try to do before you in describing *the major symptoms of hysteria*. This word *major* indicates well that I do not pretend to describe all possible hystericals or all the shades these symptoms may present, but that I only wish to show you what, in my hypothesis, characterizes the typical symptoms of hysteria. Such symptomatic and hypothetic descriptions have the inconvenience of being transitory, of disappearing very soon after us, but it would be a singular illusion to seek to do something eternal. One has already obtained a great result when one has done something momentarily intelligible and useful. Charcot,

whose method I cited to you, applied it in a rather exaggerated degree in his description of hysteria; he described a type of hysterical which disappeared with him; nobody nowadays any longer describes the attack of hysteria as Charcot did. I think, however, that his description did service to many a generation of students. It brought about an enormous scientific movement, which we continue by discussing it. No doubt, our types of hysterical phenomena are ephemeral like his. We wish they may have the same usefulness for some time.

If I succeed in presenting to you a few simple types, intelligible for you, of the mental state that is called somnambulism, of the mental state that brings about the functional paralyses and insensibilities, I shall, I hope, have interested you in these studies of pathological psychology, indispensable nowadays to the understanding of philosophical and moral problems; I shall have helped you a little to play later on your part as physicians, for a physician should attend to the thought of his patient; I shall thus have accomplished, partially at least, the wishes formed by your masters of Harvard school when they did me the great honour to call me among them.

LECTURE II.

MONOIDEIC SOMNAMBULISMS

Somnambulism as the typical form of hysterical accidents — Description of some cases of monoideic somnambulisms — Their essential psychological characters — The emancipation, the dissociation of an idea, of a partial system of thoughts in somnambulism

THE several conceptions of an illness are characterized by the choice of the symptoms described first and considered as the most important ones. During a long time hysteria was considered as a chiefly physical disease, and consequently convulsions, in all appearance deprived of intelligence, were put on the first line. Hysteria was, above all, a convulsive illness whose most important symptom was the fit. Charcot has still continued that tradition, and you know the pains he took to explain all that illness in taking as a starting-point the convulsive attack. His theory is nowadays considered very artificial, and his schematic conception of the attacks tends to fall into oblivion; that lack of success I easily explain through his error of the starting-point. The hysterical fit of convulsions, far from being a simple phenomenon, is, on the contrary, a very variable and complex symptom. The convulsions have all sorts of meaning; sometimes they are in connection with sensations or ideas and very complicated states

of consciousness; sometimes they are nearly deprived of consciousness; in certain cases they are linked to habits and grimaces, or depend upon moving agitation in connection with certain voluntary paralyses. It may be said that for some rather aged patients, whose illness has lasted a long time, the convulsive attack sums up all the hysterical accidents they have had since the beginning of the disease. The attack I consider as a complex phenomenon that ought to be studied rather at the end of a course of lectures than at the beginning. To characterize at once the spirit of my teaching and to make you understand how to construe that nervous affection from the moral point of view, I ask you to put in the first line, as the most typical, the most characteristic symptom of hysteria, a moral symptom, — that is somnambulism, — the fit of somnambulism which appears spontaneously in hystericals. This is a new medical conception which I consider an important one.

Somnambulism has been too long considered as a rare phenomenon, impossible to explain, that adds itself to the habitual troubles of neuropaths. To me somnambulism is, on the contrary, extremely frequent under various forms, that may more or less conceal it. Somnambulism does not add itself to all sorts of neuropathic troubles; it constitutes the material point of a peculiar neurosis, — hysteria. If one understands somnambulism well, one is, I believe, capable of understanding all hysterical phases that are more or less constructed on the same model.

But among the various somnambulisms, a type must be chosen to be first studied. Here we will not choose

the form that occurs most frequently, but the necessity of teaching will induce us to choose the simplest form and the easiest to understand. This simple form of somnambulism deserves to be called monoideic, and that name will, I hope, be justified by this lecture. Thus we have to examine together the typical forms of monoideic somnambulism; we shall then expose its essentially psychological character, and we shall end by trying to sum up in a simple and general conception the character of these somnambulisms, in order to compare gradually that first conception with those we shall draw from the study of other hysterical phenomena.

I

What, then, exactly, is a somnambulist? Popular observation has answered long ago: it is an individual who thinks and acts while he is asleep. Without a doubt that answer is not very clear, for we don't know very well what sleep is. That answer means only that the person spoken of thinks and acts in an odd way, different from that of other people, and that at the same time that person is in some way like a person asleep. You will find nowhere a more beautiful description of this popular conception of somnambulism than in Shakespeare's tragedy, *Macbeth*:—

Doctor. I have two nights watched with you, but can perceive no truth in your report. When was it she last walked?

Gentlewoman. Since his majesty went into the field, I have seen her rise from her bed, throw her nightgown upon her, unlock her closet, take forth paper, fold it, write upon 't, read it,

afterwards seal it, and again return to bed; yet all this while in a most fast sleep.

Doctor. A great perturbation in nature, to receive at once the benefit of sleep and do the effects of watching! In this slumbery agitation, besides her walking and other actual performances, what at any time have you heard her say?

Gentlewoman. That, sir, which I will not report after her.

Doctor. You may to me, and 't is most meet you should.

Gentlewoman. Neither to you nor any one, having no witness to confirm my speech.

Enter LADY MACBETH, *with a taper*

Lo you, here she comes! This is her very guise; and, upon my life, fast asleep! Observe her; stand close.

Doctor. How came she by that light?

Gentlewoman. Why, it stood by her; she has light by her continually, 't is her command.

Doctor. You see, her eyes are open.

Gentlewoman. Ay, but their sense is shut.

Doctor. What is it she does now? Look, how she rubs her hands.

Gentlewoman. It is an accustomed action with her, to seem thus washing her hands; I have known her continue in this a quarter of an hour.

Lady Macbeth. Yet here 's a spot.

Doctor. Hark! she speaks; I will set down what comes from her, to satisfy my remembrance the more strongly.

Lady Macbeth. Out, damned spot! out, I say! — One, two; why, then 't is time to do 't. — Hell is murky! — Fie, my lord, fie! a soldier, and afeard? What need we fear who knows it, when none can call our power to account? — Yet who would have thought the old man to have had so much blood in him?

Doctor. Do you mark that?

Lady Macbeth. The thane of Fife had a wife; where is she now? — What, will these hands ne'er be clean? — No more o' that, my lord, no more o' that; you mar all with this starting.

Doctor. Go to, go to; you have known what you should not.

Gentlewoman. She has spoke what she should not, I am sure of that; heaven knows what she has known.

Lady Macbeth. Here 's the smell of the blood still; all the perfumes of Arabia will not sweeten this little hand. Oh, oh, oh!

Doctor. What a sigh is there! The heart is sorely charged.

Gentlewoman. I would not have such a heart in my bosom for the dignity of the whole body.

Doctor. Well, well, well, —

Gentlewoman. Pray God it be, sir.

Doctor. This disease is beyond my practice; yet I have known those which have walked in their sleep who have died holily in their beds.

Lady Macbeth. Wash your hands, put on your nightgown; look not so pale. — I tell you yet again, Banquo 's buried; he cannot come out on 's grave.

Doctor. Even so?

Lady Macbeth. To bed, to bed! there 's knocking at the gate; come, come, come, come, give me your hand. What 's done cannot be undone. To bed, to bed, to bed! [*Exit.*

Doctor. Will she go now to bed?

Gentlewoman. Directly.

Doctor. Foul whisperings are abroad. Unnatural deeds
Do breed unnatural troubles; infected minds
To their deaf pillows will discharge their secrets.
More needs she the divine than the physician. —
God, God forgive us all! — Look after her;
Remove from her the means of all annoyance,
And still keep eyes upon her. So, good night;
My mind she has mated, and amaz'd my sight.
I think, but dare not speak.

Gentlewoman. Good night, good doctor.

[*Exeunt.*

Our modern examples are much less dramatic, but they may be compared as to their most striking features. Let me cite a certain number of cases to impress upon

your mind the idea of this phenomenon, which to me is a very important one. Here is a first instance: A young woman, twenty-nine years old, called Gib., intelligent, sensitive, hears one day abruptly some disastrous news. Her niece, who lives next door, has just died in dreadful circumstances. She rushes out, and comes, unhappily, in time to see the body of the young girl lying in the street. She had thrown herself out of the window in a fit of delirium. Gib., although very much moved, remains to all appearance calm, helping to make everything ready for the funeral. She goes to the funeral in a very natural way. But from that time she grows more and more gloomy, her health fails, and we may notice the beginning of the singular symptoms we are going to speak of. Nearly every day, at night and during the day, she enters into a strange state; she looks as if she were in a dream, she speaks softly with an absent person, she calls Pauline (the name of her lately deceased niece), and tells her that she admires her fate, her courage, that her death has been a beautiful one. She rises, goes to the windows and opens them, then shuts them again, tries them one after another, climbs on the window, and, if her friends did not stop her, she would, without any doubt, throw herself out of the window. She must be stopped, looked after incessantly, till she shakes herself, rubs her eyes, and resumes her ordinary business as if nothing had happened.

A curious case I have lately observed is that of He., which I have related with more particulars in another of my works. That woman, a hysterical thirty-five

years old, was taking a walk in the zoological garden during her menstrual period, when she was frightened by a lioness that, as it was reported, seemed ready to rush upon her. When she came back to the hospital, she had a fit of delirium that lasted for eight days. After some interruption, she again had fits of the same odd delirium. In these crises she runs on all fours, roars, rushes on people, trying to bite them; and although she was anorexic before her attack and could eat very little, now she pounces on all sorts of food, picks it up with her teeth, and devours bits of paper and small objects she finds on the floor. In a word, she acts a comedy wherein she believes herself to be a lioness. I say that she acts a comedy, for it becomes certain that she studies her part, and that she often replaces real actors by metaphors. For instance, she looks in a drawer for photographs, generally children's portraits, and tries to eat them up. Without any doubt, as she is unable to devour real persons, she devours them in effigy. I won't insist on the form here borrowed by the idea rooted in her mind; it is one of those changes in personality brought about by a suggestion or an invading idea which are already well known. At the same time we may observe in He., when she is awake, a very complete amnesia, that spreads not only upon the delirium, but also upon the walk at the zoological garden.

Third observation: A man of thirty-two, Sm., presents a still more singular case. He usually remains in bed, for both his legs are paralyzed. We won't occupy ourselves with that paralysis to-day, although it is a very odd one. In the middle of the night he rises

slowly, jumps lightly out of bed, — for the paralysis we have just spoken of has quite vanished, — takes his pillow and hugs it. We know by his countenance and by his words that he mistakes this pillow for his child, and that he believes he is saving his child from the hands of his mother-in-law. Then, bearing that weight, he tries to slip out of the room, opens the door, and runs out through the court-yard; climbing along the gutter, he gets to the housetop, carrying his pillow and running all about the buildings of the hospital with marvellous agility. One must take great care to catch him, and use all sorts of cautions to get him down, for he wakes with a stupefied air, and as soon as he is awake, both his legs are paralyzed again, and he must be carried to his bed. He does not understand what you are speaking about, and cannot comprehend how it happens that people were obliged to go to the top of the house in order to look for a poor man who has been paralyzed in his bed for months.

A fourth and last observation, for I insist upon relating to you a great number of instructive examples. We come back to the common story of a young girl twenty years old, called Irene, whom despair, caused by her mother's death, has made ill. We must remember that this woman's death has been very moving and dramatic. The poor woman, who had reached the last stage of consumption, lived alone with her daughter in a poor garret. Death came slowly, with suffocation, blood-vomiting, and all its frightful procession of symptoms. The girl struggled hopelessly against the impossible. She watched her mother during sixty nights, working at

her sewing-machine to earn a few pennies necessary to sustain their lives. After the mother's death she tried to revive the corpse, to call the breath back again; then, as she put the limbs upright, the body fell to the floor, and it took infinite exertion to lift it again into the bed. You may picture to yourself all that frightful scene. Some time after the funeral, curious and impressive symptoms began. It was one of the most splendid cases of somnambulism I ever saw.

The crises last for hours, and they show a splendid dramatic performance, for no actress could rehearse those lugubrious scenes with such perfection. The young girl has the singular habit of acting again all the events that took place at her mother's death, without forgetting the least detail. Sometimes she only speaks, relating all that happened with great volubility, putting questions and answers in turn, or asking questions only, and seeming to listen for the answer; sometimes she only sees the sight, looking with frightened face and staring on the various scenes, and acting according to what she sees. At other times, she combines all hallucinations, words, and acts, and seems to play a very singular drama. When, in her drama, death has taken place, she carries on the same idea, and makes everything ready for her own suicide. She discusses it aloud, seems to speak with her mother, to receive advice from her; she fancies she will try to be run over by a locomotive. That detail is also a recollection of a real event of her life. She fancies she is on the way, and stretches herself out on the floor of the room, waiting for death, with mingled dread and impatience. She

poses, and wears on her face expressions really worthy of admiration, which remain fixed during several minutes. The train arrives before her staring eyes, she utters a terrible shriek, and falls back motionless, as if she were dead. She soon gets up and begins acting over again one of the preceding scenes. In fact, one of the characteristics of these somnambulisms is that they repeat themselves indefinitely. Not only the different attacks are always exactly alike, repeating the same movements, expressions, and words, but in the course of the same attack, when it has lasted a certain time, the same scene may be repeated again exactly in the same way five or ten times. At last, the agitation seems to wear out, the dream grows less clear, and, gradually or suddenly, according to the cases, the patient comes back to her normal consciousness, takes up her ordinary business, quite undisturbed by what has happened.

I could tell you many more of these examples, for all the events of life may be reflected in one of these scenes. This patient acts over again a scene wherein he has been bitten by a dog; that one reproduces in his dream the emotion he had when he was wounded by the falling of the lift. This little girl fancies a scene of her school life, in which she was severely punished; that young girl reflects a scene of ravishment; a young boy repeats a quarrel in the street; another man lives through a chapter he has read in a novel, where thieves get through a latticed window and bind him tightly to his bed. This kind of delirium may vary over and over again in a thousand different ways. It is, however, very character-

istic, and in all mental pathology you will not find another delirium that may be compared with it. It is then necessary to study carefully the psychological character of which it is made up; for the precise analysis of this simple delirium will perhaps be the starting-point whence we shall proceed to explain the other more complicated states.

II

Innumerable studies have been written to analyse the preceding state in every particular. I shall only sum up the very clear result of those studies, and I shall do it by following that state from its starting-point to the return of normal life. There is a first very important period, but on it we cannot yet dwell; it is the moment when somnambulism begins, the change from the normal to the second state. When the change is sudden, there is, as it seems, a loss of consciousness, a half faint. When the change is slow, one may easily observe the abasement of mental activity; the patient pays no more attention to exterior events; he understands less and less what you tell him, and he answers with difficulty, is absent-minded, works more slowly, or interrupts his work. In short, voluntary activity and close application seem to disappear, to give place to the expansion of the dream.

When the dream begins, you may note a very striking and important characteristic; namely, the perfection and the intensity of its development. All the phenomena in connection with the dream seem enormously

increased. Undoubtedly we all take expressions and attitudes in connection with our thought, but our expressions look shabby and incomplete in comparison with the marvels of plasticity we may sometimes observe in somnambulism. Some of the patients, as we have already remarked, neither speak nor move, but remain fixed in an expressive attitude. That form of monoideic somnambulism is called catalepsy. We have no time to dwell on all its various forms; we will only point out the perfect expression of those living statues that have often inspired superstitious wonder.

We may learn by different means what images fill his consciousness, and we may see that he has not our dull memory of things, but that he sees the objects he speaks of, and really hears, feels, touches them exactly as if they were real. The unfolding of hallucinations is incomparable, and except in some crises of alcoholic delirium, that are a little like hysteria, we shall never find in lunacy such abundance and such copiousness in the hallucinations of all senses. When the patient speaks, he has a fluency of elocution and even an eloquence that seems superior to his normal powers, because he gives himself entirely up to the idea he means to express. When he acts, he has a precision and quickness in his movements that make a wonderful actor of him, and here, again, he surpasses his usual powers. The patient we just spoke of, the one who believed he was rescuing his child by carrying his pillow, ran on the housetop with more agility than he would have shown in his normal state, even if he had not been palsy-stricken. One of my patients who does not know how

to write, writes during her somnambulism. It is no wonder, and there is no mystery about the case; in the somnambulic state that woman remembered the writing she had learned at school, as a child, and had to all appearance forgotten thirty years ago.

The development of the somnambulic delirium is not only intense, it is also perfectly regular. The patient repeats the same words at the same moments, makes the same gestures at the same place, every time he begins his performance over again. He seems to have on that point a marvellous memory; when he has appropriated his somnambulism to a given room, he remembers all that he did at each different spot; he knows from what drawer he took the photos he pretends to eat up, in what table he found a bit of wood that he used as a pistol; he goes directly to that spot, unhesitating, knowing exactly what he expects to find there. Sometimes, in the course of various somnambulisms, the patient, instead of beginning his history over again, takes up his delirium at the exact point where he last stopped, and seems to remember perfectly at what point he broke off in his last delirium. You recollect one of Charcot's somnambulists who believed himself a journalist and who wrote a novel; he waked after writing two or three pages, which were taken away from him. In the next crisis, he began his novel exactly at the point where he had broken off. You see what an important part regularity and memory play in these scenes. Inversely, the patient's liberty or power of will seem to have no share in these crises, for the scene is never altered in the way the patient could wish.

This negative character will become even more striking if we study somnambulism from another point of view.

In contrast with the brilliant unfolding of some phenomena, we discover with amazement strange mental blanks. The same patient who looks as if he had very precise sensations, since he can walk on the house's top, look for objects in a drawer, and see very clearly the bed where, in his fancy, his mother lies dying, — this same patient seems unable to grasp anything else. This is what first struck popular observation. Speak to them and they do not answer; try by all sorts of means to make your presence felt, they do not seem to feel it. The objects you thrust before their eyes do not in the least alter their dream, and do not in the least stop it; as the doctor remarks in the case of Lady Macbeth, their eyes seem open, but they are shut to all impressions that are not connected with their dream. To make yourself heard, you must dream with the patient and speak to him only words in accordance with his delirium.

As the patient perceives nothing except the idea he is possessed of, he remembers nothing except that one idea. He knows not where he is; he has quite forgotten the changes that have taken place since the time he speaks of; he often does not even know his name. His memory, as well as his sensations, is shut up in a narrow circle.

The somnambulism is ended; the patient comes back to consciousness. We may then notice new characteristics and see how they add themselves to the preceding ones. The patient resumes his former sensations; the

memory he has lost comes back, he knows his name, knows also where he is, and remembers all the events of his life; he has, to all appearance, his former character and personality; but the wonderful thing is, that, in this new personality, somnambulism has left a gap. He appears to have forgotten all that preceding period that amazed us to such a point by its dramatic character. He is not disturbed by it; he does not endeavour to apologize for the ridiculous acts he has just accomplished; he wonders sometimes at the untidiness of the room, of which he is himself the cause, and cannot understand how it came about. If you question him, try to awaken his memory by direct questions, either of two things may happen. In describing with too much accuracy what the patient has just done in his delirium, you will either revive his memory so vividly that he will fall back again into the preceding state, be wholly taken up by that recollection, forget that you are there and act the whole scene over again; or, as more frequently happens, you will be unable to recall to his mind the lost memory. He does not understand what you mean. All the preceding scene which in reality is so lively and persistent in his memory, since it will begin over again, or will enter in the next crisis, seems at that moment quite out of his consciousness. These are the chief psychological characteristics that come out in somnambulism. During the crisis itself, two opposite characteristics manifest themselves; first, a huge unfolding of all the phenomena connected with a certain delirium; second, an absence of every sensation and every memory that is not connected with that delirium. After the crisis, during

the state that appears as normal, two other characteristics appear, opposite, to all appearance: the return of consciousness of sensations and normal memory, and the entire forgetfulness of all that is connected with the somnambulism. Let us remember all these notions that here seem very simple, and we shall afterwards see them unfolded in every hysterical phenomenon.

III

The facts and the laws of somnambulism we have just described have been well known for a long time, and usually they made up all that was studied about this curious state. But I believe that we must notice another interesting fact in order to understand better the whole of the monoideic somnambulism. This fact is usually more or less concealed, but it becomes very apparent and conspicuous in certain cases.

Let us take up the case of that young girl, Irene,[1] who acts during her somnambulism the scene of her mother's death with such apparent precision. Let us watch her during the intervals of her fits, during the period in which she seems to be normal; we shall soon notice that even at that time she is different from what she was before. Her relatives, when she was conveyed to the hospital, said to us: "She has grown callous and insensible, she has soon forgotten her mother's death, and does not seem to remember her illness." That remark seems amazing; it is, however, true that this

[1] Cf. "L'amnesie et la dissociation des souvenirs par l'émotion," *Journal de psychologie normale et pathologique*, 1904, p. 417.

young girl is unable to tell us what brought about her illness, for the good reason that she has quite forgotten the dramatic event that happened three months ago. "I know very well my mother must be dead," she says, "since I have been told so several times, since I see her no more, and since I am in mourning; but I really feel astonished at it. When did she die? What did she die from? Was I not by her to take care of her? There is something I do not understand. Why, loving her as I did, do I not feel more sorrow for her death? I can't grieve; I feel as if her absence was nothing to me, as if she were travelling, and would soon come back." The same thing happens if you put to her questions about any of the events that happened during those three months before her mother's death. If you ask her about the illness, the mishaps, the nightly staying up, anxieties about money, the quarrels with her drunken father, — all these things have quite vanished from her mind. If we had had time to dwell upon that case, we should have seen these many curious instances: the filial love, the feeling of affection she had felt for her mother, have quite vanished. It looks as if there was a gap as well in the feelings as in the memory. But I shall insist only on one point: the loss of memory bears not only, as is generally believed, on the period of somnambulism, on the scene of delirium; the loss of memory bears also on the event that has given birth to that delirium, on all the facts that are connected with it, on the feelings that are related to it.

This very important remark may be extended to all the other cases I have related. He., who has the de-

lirium in which she fancies herself a lioness, has not only forgotten this period of somnambulism, but also the walk in the zoological garden, that first cause of her delirium. Sm., who carries his pillow on the house-top, believing that he is rescuing his child from the clutches of his mother-in-law, does not remember his quarrels with that woman, although those quarrels were the starting-point of the actual disease.

I have noted down in this connection a very singular observation, in which this retrograde amnesia accompanying somnambulism is well brought into evidence.[1] A young girl, nineteen years old, Lie., has fits of somnambulism in which she speaks about thieves, about a fire, and calls to her help a certain Lucien. When awakened, she knows nothing about all this, and when you speak to her of what she said, she pretends that in her life there is no event in which any part was played by thieves, by a fire, or by Lucien. As she had come alone to the hospital, we had no other information, and were compelled to believe that she had an imaginary delirium. Six months afterwards only, some relatives of hers, who had come from the country to see her, told us of an event that happened three years before, and was the starting-point of her nervous crises. She was a servant in a country seat which one night was robbed and set on fire by thieves, and she was rescued by a gardener called Lucien. It is astonishing that this young girl could have utterly forgotten such an important event, and that she was never able to speak about it when she

[1] Cf. "Nevroses et Idees fixes," 1898, Vol. II, observation 69, p. 234.

related to the physician the story of her life and the beginning of the disease. It is worthy of note that the forgetfulness of this fact coincides with the development of that extraordinary memory on the same subject that filled her somnambulism.

Without any doubt the forgetfulness of the idea which plays the greatest part in the monoideic somnambulism is not always so clear, so perfect. But I believe this forgetfulness always exists more or less concealed, and the profundity of the forgetfulness is in proportion to the depth, the serious nature of the somnambulism itself. According to my belief, the somnambulism is followed by an amnesia which is retrograde, and bears not only on the somnambulism itself, but also on all the facts, the memories related to it. I beg the observers who can study such cases of somnambulism to notice with great care these troubles of memory added to the disease.

How can we understand, how can we picture to ourselves the whole of these facts? What is the essential point which can sum up the observations? I propose to you the following psychological interpretation. An idea, the memory of an event, for instance, the thought of a ferocious animal, the thought of a mother's death, — all these form groups of psychological facts closely connected with one another; they are certain kinds of systems comprising all sorts of pictures and all sorts of tendencies to certain movements, but with a strong unity. These systems in our minds have their strength and their law of development that are peculiar to them. They have also a great tendency to development

when they are not kept within bounds by another power.[1]

Allow me to represent to you this system of psychological facts, which constitutes an idea, by a system of points connected together by some lines, forming a sort

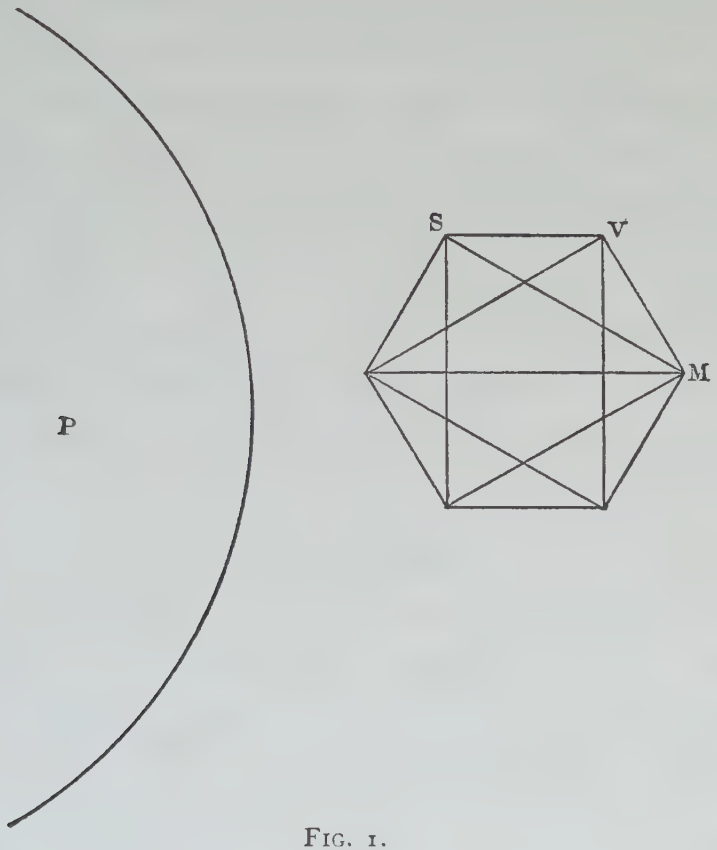


Fig. 1.

of polygon (Fig. 1). The point *S* represents the sight of the face of the dead mother, the point *V* is the sound of her voice; another point, *M*, is the feeling of the movements made to carry up the body, and so on. This polygon is like the system of thoughts which was

[1] See these laws of development of the mental systems in my first book, "L'automatisme psychologique," 1889.

developed in the mind and in the brain of our patient Irene. Each point is connected with the others, so one cannot excite the first without giving birth to the second, and the entire system has a tendency to develop itself to the utmost.

But at the same time in healthy minds these systems pertaining to each idea are connected with an infinitely wider system of which they are only a part, — the system of our entire consciousness, of our entire individuality. The remembrance of the mother's death, even the affection Irene feels for her mother, with all the memories that are connected with it, forms only a part of the whole consciousness of the young girl with all its memories and other tendencies. Let this large circle, *P*, near the little polygon represent the whole personality of the girl, the memory of all that happened in her previous life.

Normally, in good health, the little system must be connected with the large one, and must in great part depend on it. Generally the partial system remains subject to the laws of the total system: it is called up only when the whole consciousness is willing, and within the limits in which this consciousness allows it.

Now, to picture to ourselves what has taken place during somnambulism, we may adopt a simple provisional *resume*. Things happen as if an idea, a partial system of thoughts, emancipated itself, became independent and developed itself on its own account. The result is, on one hand, that it develops far too much, and, on the other hand, that consciousness appears no longer to control it. That general remark may still

seem to you very vague and very difficult to understand. Nevertheless, I wished to point it out to you in a few words: first, because it emerges very clearly out of the study of the first phenomenon of hysteria; secondly, because it will serve us as a clew to understand a thousand other cases of the neurosis. Don't trouble about the obscurity of that first remark; after you have repeated it exactly in the same way with regard to a thousand different phenomena, it will not be long before you find yourself understanding it clearly.

LECTURE III

FUGUES AND POLYIDEIC SOMNAMBULISMS

Transformations and exaggerations of the first somnambulisms — Several cases of fugues — The laws of fugues — The diagnosis of hysterical fugues — Differences between fugues and monoideic somnambulisms — The characters of polyideic somnambulisms and their relations to the simpler forms — The emancipation of feelings and emotions

A GREAT many hysteric accidents are directly connected with the kind of somnambulism we have just studied. They are only slight transformations of the same phenomenon. Sometimes somnambulism increases, develops in a particular direction, sometimes it diminishes, keeps back only a few symptoms, and it is sometimes difficult to know it again. But the phenomena are still of the same kind; they must be explained in the same manner, and, if we wish to understand hysteria well, it is very important we should know the possible transformations of that fundamental state of somnambulism. To-day, and in our next lecture, we shall study the exaggerations and developments that multiply to a very high degree our first monoideic somnambulism. The first fact we meet with, in this direction, is one of the most wonderful phenomena of hysteria, the study of which has already attracted many authors. This fact is the hysterical mania of running

away that we call ambulatory automatism, flights, or better, fugues, if we may keep the French word.

I

We shall begin, as we are wont to, by showing you a certain number of clinical cases, as if the patients were here before your eyes. We shall thus more easily acquire the knowledge of the clinical characters and of the general idea that is to be derived from them.

Here is a splendid case of hysterical fugue, remarkable for its simplicity. You can find the entire description of it in the *Gazette des Hopitaux*, where I published it with Professor Raymond on the second of July, 1895. The subject is a man, P., thirty years old, employed in a railway station in a town in the east of France. Although an active and clever fellow, he was a little eccentric, and had already led a somewhat adventurous life. In his youth he had had frequent fits of somnambulism, sometimes in the day, but mostly at night. Moreover, the tendency to somnambulisms is to be found in his family, since his brother was also a nocturnal somnambulist, who got out of his bed while asleep to work at his exercises. One day, like a patient we have spoken of, he carried his pillow on the housetop, mistaking it for a little baby. If I dwell upon these previous somnambulisms similar to those we have already described, it is because they form a link between the first phenomena we have spoken of and those we shall describe to-day. This man, P., was also very easily affected, predisposed to fixed ideas. One day, in the

notary's office where he worked, he was slightly suspected, though not accused, of stealing a trifle. He fell ill, and was very distressed. Night and day he discussed that suspicion, and, although everybody tried to prove to him how trifling it was, he could not remain in that office. Moreover, he had a tendency to exaggerated fears. He had left Lorraine after its annexation to Germany, and during many years he was haunted by the fear of the German police, whom he always believed to be running after him. All those details have their importance: you must not forget thus to inquire into the previous character of your patients; such an inquiry will often enable you to understand very well the neuropathic diseases that come on later. However that may be, the man we are talking of had also an adventurous turn of mind. He started with the Crevaux mission on an expedition to South Africa, and was sent back to France on account of his health. Then he enlisted under the orders of De Brazza, who was starting for Gabon. There, we must also notice, he was very much debilitated by diseases peculiar to hot climates, and continued long after his return to have fits of the ague. This also is serious enough to prepare the way for the ensuing mental weakness.

On his return to France, at the age of twenty, he got a situation in a railway company, and was soon in easy circumstances. He married, and had a child he dearly loved. His wife was again pregnant when the following incident took place. Although he led a quiet and rather happy life, he was uneasy in his mind, and gave himself up to intellectual labours too hard for a man

who had no great acquirements. To his work in the railway office he added bookkeeping and, what is more, he drew up a geographical account of Gabon from the notes he had taken, and this work gave him much trouble. He was made uneasy in his mind by family quarrels: his brother, who was jealous of him, had just quarrelled with him and had charged him with shameful and dishonest acts. The charge was groundless, and nobody around him troubled about it, but we know how easily upset, how susceptible he was in that quarter, and how he lost his head at the mere idea of a charge of that kind.

It is in these conditions that we come to the third of February, 1895. He was alone at Nancy, his wife having left him for a few days. He had just ended a chapter of his work on Gabon, and, to take a little rest, he went to a coffee-house where he was well known. During the afternoon, a part of which he spent with some friends at this coffee-house in playing billiards, he drank a cup of coffee, two glasses of beer, and a small glass of vermouth which the coffee-house keeper wished him to taste. He told us himself all these circumstances, which he remembers quite well. He also knows that one of his neighbours came to the coffee-house and invited him to dinner, as he was alone at home. He accepted the invitation. So everything was as it should be, and he has a very exact memory of all that happened then. He left that coffee-house about five, ready to go and dine with his friend; but a few yards off, while crossing the Stanislas bridge over the railway line, just as he got to the middle (that also he

perfectly remembers), he felt a violent pain in his head, as if he had been struck on the posterior part of his head. I point out these sensations to you without being able to dwell on them, for they have not as yet been sufficiently accounted for. But it is necessary you should know they often occur in the same conditions with neuropathic patients. The blow in the occiput is very often characteristic of great fits, of great changes of personality. It is just what happened in this case, for immediately after that something must have changed in the mental state of our patient, as he has entirely lost the memory of all that happened afterwards on that Sunday, the third of February, 1895, and on the following days.

When he comes back to consciousness, or rather when he resumes the thread of his recollections, the circumstances are changed to an extravagant degree. His first recollection is the following: he was lying in a field, covered with snow, half dead, and amazed to find himself in that place; he got up painfully, found a road with a tramway line, walked along that line, and finally got, not without difficulty, to a town quite unknown to him, near a railway station. It was the South Station at Brussels. It was eleven o'clock in the evening, and the date he read in a newspaper was the twelfth of February. In short, he had felt a shock on the head at Nancy on the third of February, and awoke in the neighbourhood of Brussels on the twelfth. All that had happened in the meantime, how he accomplished that singular journey, he does not in the least know.

He telegraphed to ask for assistance: he was taken

care of and conveyed to Paris to the Salpetriere, where we studied his case. I will not now explain to you how we revived his recollections; it would imply notions on hysteria that you have not yet acquired. I shall only tell you that we contrived to know what happened during those nine days, and that we may now add it to the story of his fugue.

On the Stanislas bridge, after he had felt the blow on the head, he felt himself overwhelmed with fear at the thought of the charge brought against him by his brother, so that he went home in great anxiety. A few slight occurrences, too long to tell, increased the feeling of guilt, and in the evening, which he spent in wandering about the streets without going to his neighbour's for dinner, he constantly pondered on the way to escape those accusations and on the means of running away. He returned home, where he took some money, and went to sleep in an hotel in the suburbs instead of remaining quietly at home. He rose early, and avoiding the railway, went on foot through the fields to Champigneul. When he had arrived there he went to the railway station, where he was not known, and took a ticket for Pagny on the Moselle; from Pagny he walked to Longwy, still avoiding with the greatest care the persons who, he fancied, were running after him. And in fact he did avoid them very well, for his disappearance had been noticed, and he was sought after with great anxiety. At Longwy he took the train to Luxemburg, then to Arlon and to Brussels, still with the rooted idea of taking refuge in a foreign country under a false name, in order to escape pursuit. At Brussels, he first went

to a good hotel and spent his days in seeking the means of earning a few pence. But he did not succeed, and his small means dwindled away. He took lodgings in a very shabby room, then in one of those asylums where poor people are lodged at night. There a good man had pity on him and gave him a letter of introduction to a charitable foundation. That letter played afterwards an important part, for he found it again in his pocket after waking up, and it enabled him, at the time of his recovery, to retrace the former events and to recollect what had happened. But on the day it was given to him he did not use it, so that he fell into the most terrible poverty. He was on the point of enlisting for the Dutch Indies; but, happily, he was not accepted. Fancy that unhappy man in the midst of a crisis of somnambulism sailing for India. Exhausted with fatigue and want of food, he stretched himself on the snow in the fields with the vague idea that he was about to die.

Here something very extraordinary happened, something very interesting as a psychological fact. As he thought he was at the point of death, he could not help changing the bent of his thoughts, and in spite of himself, he thought that he would like to see his family before he died, stretched out in the snow. You must notice that the thought of his family had never entered his mind during the last days. The appearance of this idea had an unexpected result. He immediately said to himself, "But, after all, why am I dying here, far from my family?" He got up; he was awake: you know what happened afterwards. I want only to point

out to you that enormous change in the mental state brought about by an idea.

The fact is so interesting, that we must observe it a second time in another case I have studied; it is also a very strange one. I will only sum up the more important facts. If you care to read this entertaining observation, you will find it at full length in the second volume of my work on neuroses and fixed ideas.[1] Here I shall only state the facts that are interesting for us to-day.

The subject is a boy of seventeen, Rou., son of a neuropathic mother, rather nervous himself, who already had, when he was ten years old, tics and contractures in the neck, of which we shall speak in one of our following lectures. At thirteen he often went to a small public house, visited by old sailors. They would urge him to drink, and, when he was somewhat flustered, they would fill his imagination with beautiful tales in which deserts, palm trees, lions, camels, and negroes were pictured in a most wonderful and alluring way. The young boy was very much struck by those pictures, particularly as he was half tipsy. However, when his drunkenness was over, the stories seemed to be quite forgotten; he never spoke of travels, and, on the contrary, led a very sedentary life, for he had chosen the placid occupation of a grocer's boy, and he only sought to rise in that honourable career.

Now there come on quite unforeseen ~~accidents~~ attacks, almost always on the occasion of some fatigue or a fit of drunkenness. He then felt transformed, forgot to

[1] "Nevroses et Idees fixes," II, p. 256.

return home, and thought no more of his family. He would leave Paris, walking straight ahead, and go to a more or less great distance through the forest of St. Germain, or as far as the department of the Orne. Sometimes he walked alone; at other times he rambled with some tramps, begging along the roads; he had but one idea left in his head; namely, to get to the sea, enlist in a ship and sail away towards those enchanting countries of Africa. His journeys ended rather badly; he would awake suddenly, drenched, half starving, either on the highroad or in an asylum, without ever being able to understand what had happened, without any memory of his journey, and with the most ardent wish to go back to his family and his grocery.

I will dwell on only one of his fugues, which is particularly amusing, and was of extraordinary duration, for it lasted three months. He had left Paris about the fifteenth of May, and had walked to the neighbourhood of Melun. This time he was thinking about the means of succeeding in his scheme and of getting safely to the Mediterranean. Until then he had failed, owing to fatigue and misery: the question was to find means of living as he went along. A bright idea had occurred to him; not far from Melun, at Moret, there are canals that go more or less straight to the south of France, and in those canals there are ships laden with goods. He succeeded in being accepted as a servant on a ship laden with coal. His work was terrible; now he had to shovel the coal, now to haul the rope in company with a donkey called Cadet, his only friend. He was badly fed, often beaten, exhausted with fatigue, but, though

you would scarcely believe it, he was radiant with happiness. He thought only of one thing, — of the joy of drawing nearer to the sea. Unhappily, in Auvergne, the boat stopped, and he was forced to leave it and continue his journey on foot, which was more difficult. In order not to be resourceless, he hired himself as a helper to an old china mender. They went slowly along, working on the road.

Then, one evening, an unlooked-for event took place again. The day's work had been a success; the two companions had earned seven francs. The old china mender stopped and said to R., "My boy, we deserve a good supper; and we will keep to-day's feast; it is the fifteenth of August." On hearing this, the boy heedlessly said: "The fifteenth of August? Why, it is the feast of the Virgin Mary, the anniversary of my mother's name-day." He had scarcely uttered these words when he appeared to be quite changed. He looked all around him with astonishment, and turning to his companion, said, "But who are you, and what am I doing here with you?" The poor man was amazed, and was quite unable to make the boy understand the situation; the latter still believed himself in Paris, and had lost all memory of the preceding months. They had to go to the village mayor's, where, with great difficulty, the matter was made more or less clear. The mayor telegraphed to Paris, and the prodigal child was sent back home. Is not that name, which suddenly evoked the memory of his mother and awakened him likewise, a pretty conclusion of a fugue?

The same particular is to be found in this final observation, which I will relate in a few words. A young man of twenty-nine, a clerk at a notary's office, had made a fugue of the same kind as the preceding ones, and impelled by a fixed idea, had gone as far as Algeria. He found himself at Oran, sitting on the terrace of a coffee-house, quietly reading his newspaper, when his eyes fell on a singular piece of news. The newspaper related the story of the sudden disappearance of a young notary's clerk, aged twenty-nine, of such a name, and wondered what had become of him. "Why," thought the young man, quite amazed, "I am that young man; what can have happened?" And he awoke without remembering his freak in the least. You see that the three observations are very much alike. It was formerly thought that such cases were very rare, and that they each had particular characters. In reality it is not so, and we could easily collect twenty very typical instances quite similar to the three we have just described, and in which you would easily recognize the same features.

II

Let us then try and find the characteristic feature of the observations we know. You have noticed yourselves, while listening to me, how obvious the analogy is between the phenomena called hysterical fugues and the monoideic somnambulisms we lately studied. In a general way, the essential characters are the same, and we could without difficulty apply to the former the

four laws we applied to the latter. First, during the abnormal state there is a certain idea, a certain system of thoughts that develops to an exaggerated degree. It is evident that P., for instance, constantly thinks, during the eight days his fugue lasts, of the charge brought against him by his brother, of the consequences it may have for him, and of the means of eluding capture. It is obvious that the young R. ponders during three months over the means of getting to the Mediterranean and the hope of finding a ship there and sailing for Africa. Such thoughts are disproportionate to the situation of a railway officer, the father of a family, and to that of a grocer's boy. They bring about certain acts, they add to the endurance of those people who travel on foot, work, and bear hardships without difficulty.

The second law applies equally well. During the abnormal state, the other thoughts, relating to the former life, the family, the social position, the personality, appear to be suppressed. It is very likely that during their fugues those people assume false names, and create for themelves fictitious personalities; you will find with regard to this last detail an interesting observation in the paper of Mr. H. Coriat of Boston, published in the third number of *The Journal of Abnormal Psychology*, 1906, p. 109. The important point is that these people have lost the memory of their real personality. This seems strongly confirmed by the phenomenon of the awakening. When some chance occurrence brings back to their mind a thought about their family, their real name, their former self, they fall into another system of ideas and wake up. This proves conclusively

that, during the abnormal state, chance had not roused that category of recollections.

Outside of the time of the fit or of the abnormal state, and during the period considered as normal (you already guess it is not entirely so), the two inverse laws apply. The recollections of the fugue have vanished, and that to an extraordinary extent. But, at the same time, the thoughts and feelings connected with an idea that predominated during the fugue have disappeared more or less completely. I have already pointed out to you that young R. was a model grocer's boy, taking much interest in the sugar and coffee trade, dreaming only of the pleasure of going on Sundays with his mother to the Saint-Cloud fair, and having none of the tastes of an adventurous sailor. He does not continually feel this longing for travels, and even grieves very much when you speak to him about his fugues. He is afraid they may begin again, since he comes of himself to the hospital in order to get advice and be rid of them. I insist on that point. If the boy really had, all the time, a taste for travels beyond the seas, a taste which after all he might have, he would not feel troubled about his fugues; he would resign himself, in the idea that, if they were successful, they might prove profitable to him. But he is far from doing so, for, during his normal life, his feelings are not the same as during the period of his fugue. You may observe the same fact in the railway clerk, P. When he is awake, he does not speak at all in the same way of the charge his brother brought against him; not only does he realize perfectly that there is no truth in it,

but he also feels that it is of no importance. He feels it is not worth while to upset his home and spoil his situation. There is obviously something in this that recalls the amnesia of her mother's death we have noticed in Irene and the disappearance of her feelings of filial love.

Lastly, during the state considered as normal you find the development of the psychological phenomena that were suppressed during the period of the crisis: recollection of the entire existence, perception of all present occurrences, exact notion of personality. In short, you see that the four characteristic laws of somnambulisms apply to such cases. If to this you add that these fugues present themselves in individuals who have already had, as I told you in the case of P., fits of somnambulism; or if you remark that such individuals are apt to present somnambulic states later on, as happened with Rou., it seems still more justifiable to bring the two phenomena together and say that, upon the whole, fugues are kinds of hysteric somnambulisms.

We must insist a little while upon this summary and this diagnosis. In my opinion, these fugues must be ranked among hysterical somnambulisms for two reasons: first, because they represent to us all the major characteristics already known of hysterical somnambulism. In the next lecture you will learn a new characteristic of this somnambulism: that it may be artificially reproduced, and that in this artificially induced somnambulism the memory of the first abnormal stage, of the fit of natural somnambulism, reappears entirely.

This new characteristic, which we shall study a little later, and which I simply allude to, can be still found exactly in the fugues we are now examining. Long after the awakening of his last fugue, when he seems to have no remembrance at all of what happened, the young Rou. can be put into artificial somnambulism and can then relate to us with amusing preciseness all his adventures in the ship laden with coal, and his friendship with the donkey, Cadet, hauling the rope with him. When all these characteristics, and especially the last one, are to be found in a fugue, it seems to me difficult to class this phenomenon apart from hysterical somnambulism without complicating and confusing all the psychological classifications. It is only when the phenomenon which seems to you similar to a fugue presents other characteristics which must be studied, that you can frame for it another classification.

The second reason we must insist upon is that fugues of this kind, exactly characterized, usually appear in the life of some subjects who have had already, or who will have later on, other phenomena connected with the accidents we know as hysterical ones. In one word, this kind of fugues appears usually in hysterical people. This last point has called forth a number of interesting debates. You must read for these discussions a paper by Dr. J. M. Courtney, of Boston, in *The Journal of Abnormal Psychology* in August, 1906, p. 123. This author quotes a number of fugues which seem to have appeared in subjects who were formerly affected by epileptic fits — in a word, in epileptic subjects. You must discuss with great care the observations, you must

examine whether these fugues have exactly the same character as the preceding ones. It is necessary, too, to determine exactly the diagnosis of the fits which preceded the fugues, the diagnosis of epilepsy. As for me, I cannot help saying that I often doubt these diagnoses, that I am not sure of the diagnosis of epilepsy in all the cases adduced by Dr. Courtney in his interesting paper. But in the end, if you find a genuine case of fugue, with all the preceding characteristics, in a subject who is on the other hand an epileptic, what do you conclude? The neuroses are not definite entities which exclude one another, they are only certain classifications of facts. In my opinion, you must only conclude that this subject, usually severely ill, usually falling into serious epileptic fits, has once had a less severe attack, which is connected with hysterical rather than with epileptical phenomena. This is rather frequent, and is not inconsistent with the important comparison we made just now of the phenomena of a fugue and those of hysterical somnambulism.

However, we must not delude ourselves, we must recognize differences. First, during the abnormal state, the idea that develops has certainly not the same power as during monoideic somnambulism; true, it directs the conduct, but it does not bring on the hallucinations and deliriums that it produced in the preceding case. When Irene had the idea of committing suicide and of getting herself crushed by a locomotive, she had not patience enough to go to the railway track and compass a real suicide; she immediately had the hallucination of the railway track, and, without more ado, lay

down on the floor of the room. Remember that difference: there is no real hallucination in the fugue. The development of the idea is less intense. Secondly, the idea is not absolutely isolated as in somnambulism; this is the most characteristic fact. Our great somnambulists, you remember, do not see or hear anything but what concerns the idea rooted in their mind; and it could not be otherwise, for, if Irene saw the beds in the room, if she heard my voice, she would not believe herself alone on a railway track. On the contrary, the patients who make fugues need a great many perceptions and recollections to enable them to travel without any mishaps. "What is most wonderful in fugues," Charcot said, "is that these individuals contrive not to be stopped by the police at the very beginning of their journey." In fact, they are mad people in full delirium; nevertheless, they take railway tickets, they dine and sleep in hotels, they speak to a great number of people. We are, it is true, sometimes told that they were thought a little odd, that they looked preoccupied and dreamy, but after all, they are not recognized as mad people; whereas Irene could not take two steps in the street, when she was dreaming of her mother's death, without being immediately taken to the asylum. So you see that the range of consciousness is not at all the same, that the mind is not distinctly reduced to a single idea. We can make the same remark concerning the state called normal: the oblivion of the fugue is total, but the oblivion of the directive idea and of the feeling connected with it is by far less distinct, and the restoration of the normal self is much more complete.

In short, the difference could, I believe, be explained in the following remark: A fugue lasts much longer than a monoideic somnambulism. While the latter lasts a few hours at most, the former lasts for months together. It is necessary for a fugue to be able to last so long that the state should approach the normal state, and that the character of somnambulism should be attenuated.

III

In order to understand that degradation, that transformation of monoideic somnambulism into the hysterical fugue, we must study states of mind which are in some manner intermediate, and they will prepare us to understand the transformations of typical somnambulism. I mean *polyideic somnambulisms*, which are opposed to the first, as their name shows, by the multiplicity of the ideas that fill them.

One instance will be enough to make you understand how somnambulism can pass from one idea to several. Here is an hysterical woman, Leg., who has led a very eventful life, and has had several very dramatic adventures, capable of upsetting her mind and filling her head with those fixed ideas that lead to somnambulisms. One day, at the period of her menstrual discharge, she had searched her lover's desk and had found a letter that confirmed her suspicions, showing her that he had deceived her. She fell into a great passion; her menstrual discharge was stopped, of course, and she had a crisis of delirium in the form of monoideic somnambulism, during which she acted the scene over again.

Another day, as she was taking a walk with her lover, she had been surprised by a violent storm and frightened by a very loud thunderclap. Her lover, it appears, had not proved courageous, and had not been equal to the task either of reassuring her or of finding a shelter for her. She got terribly angry with him, had a violent crisis of somnambulism, during which she heard the thunderclap, fainted, and then made a scene with her lover. That, again, is quite simple and conformable to the rule. Now a third story. One day, again at the period of her menstrual discharge, she stole a revolver, placed herself in ambuscade on the roadside, and saw a carriage pass by in which was her lover with her rival. She shot at them, and fell back in a crisis of delirium. Other adventures happened to her, the result of which was the same.

After all these accidents, she was admitted into the hospital, and nearly every day, on the slightest occasion, she falls into crises of delirium. These crises begin at hazard, by the recital or by the acting, as you please, of one of her adventures. She has a haggard look, trembles, and puts her hands before her face with an expression of violent terror. She shuts her eyes as if before flashes of lightning, and acts the scene of the storm; then, suddenly, without awakening, her face takes on another expression. She seems to be looking for keys, breaks open drawers, reads letters, utters shrieks of fury. Lastly, her hands grasp an imaginary revolver, she looks out at the window with an infuriated air, pulls the trigger, and falls back in a fainting fit. These three scenes and others quite like them begin

over and over again indefinitely, succeeding one another, but not always in the same order. They may last for hours together. That is again a somnambulic state. The mind is likewise concentrated on one idea, and remains closed to external things. But the ideas are manifold and bring on different comedies, during which the perceptions and memories are not the same. The unity of the somnambulism is broken; there is something foreign to the idea itself that has unified those three or four ideas and has gathered them into one crisis.

The same character may be observed, though with somewhat greater complication, in another form of polyideic somnambulism. I take as a starting-point the rather simple observation of a young girl twenty years old, Ra. This young girl, as it appears, found a situation at a tavern keeper's; the man was very brutal, and beat and abused her in every way. She got to look upon him with abhorrence, and fell into crises of delirium during which she acted over again the scenes she had lived through in the tavern. The principal one was a scene of rape; she shrieked and resisted the brutal fellow. That is a monoideic somnambulism. But, as she runs about the room, she finds a broom. Immediately she takes it, and, keeping on her face the same look of terror, she begins to sweep the room without seeming to think in the least of the scene of the rape. Another time, it appears, she found a wheelbarrow and rolled it about the yard for hours. It is clear that the act of rolling the wheelbarrow is not connected with the thought of the rape. This is, as you see, a second form of polyideic somnambulism, in which the ideas

are not modified by the memory of previous somnambulisms, but by the impression determined by outward objects which the subject still perceives.

I could show you, as a third form, somnambulisms in which the change of ideas seems to take place more easily still: simply through an association of ideas. Read again the amusing observation about the somnambulist of Mesnet already described in 1874. That man had a very varied somnambulism, during which, in turn, he acted scenes of military life, then played music or fancied himself a servant, according to the impressions he received. One idea, awakened by an association, develops into a comedy; it awakens another, then a third, and so on indefinitely. Somnambulisms are thus very complicated sometimes, and apparently filled with a great many different ideas.

But we must then ask ourselves what makes the unity of these somnambulisms. Can we still apply here the general conception which was simple in the cases of monoideic somnambulism? We summed up those states in a few words. There is a simple idea, a system of images which has separated from the totality of consciousness and has an independent development. It brings about two things: a blank in the general consciousness, which is represented by an amnesia, and an exaggerated and independent development of the emancipated idea. Now we find nothing of the kind here; we do not find one distinct idea, one precise system that has emancipated itself from consciousness; a great many different ideas seem to characterize the somnambulism.

I think for my part that the difficulty lies on the surface, and that at bottom the phenomena remain the same. The psychological systems that exist in our consciousness are very numerous, and they do not all present themselves in the same form. No doubt one of the simplest systems is the idea relative to an event. The idea of one's mother's death is a well-defined system which can be suppressed clearly or can develop separately. But there are other vaguer systems, a great number of which we shall have to study. I only point out to you for the present the system of thoughts and of tendencies that is called a feeling, or an emotion. It is not so clear as an idea, but nevertheless it exists with some unity. The feeling that arises from the fear of an ignominious charge, the feeling of curiosity for distant countries, the feeling of love and jealousy towards a lover, the feeling of bondage to a hated master, — these are systems of thoughts that it is not always easy to express in words, that are not ideas, properly so called, that may on the contrary enclose very many different ideas, but that nevertheless possess a mental unity.

Well, in polyideic somnambulisms and in fugues, it is upon this more serious feeling that the dissociation has borne. It is a feeling in its entirety, a more or less precise feeling that has separated from general consciousness, and that develops in an independent way, giving birth to these odd deliriums. A certain complexity differentiates these phenomena from somnambulism, but we apply to them the same general law and the same interpretation.

LECTURE IV

DOUBLE PERSONALITIES

The interest of the study of these rare cases — First type of double existence, the "Lady of MacNish" — The reciprocal somnambulisms — A graphic method for the representation of amnesias — Second type of double existence, Felida X. — The dominating somnambulisms — The group of complex cases — A case of artificial double existence — The true denomination of the different states — The oscillations of mental level and the dissociation of a state of mental activity

The somnambulisms which we consider as the essential phenomenon of hysteria are apt to present a new metamorphosis, whose scientific interest is very great, when they are so protracted and complicated as to give rise to what is called double existences, double personalities. I said scientific interest, rather than clinical and practical interest, because this phenomenon is, upon the whole, rather rare, and it is unlikely you will have to occupy yourselves with it in practice. A celebrated neurologist of New York — M. Dana — published in 1894 in the *Psychological Review*, p. 570, a comprehensive study on the most definite cases which have been observed, and he counted only sixteen. In the last

number of his *Journal of Abnormal Psychology*, p. 186, Dr. Morton Prince gave a fine table of twenty cases, of which he explained the most interesting features. Let us suppose there are to-day twenty-five or thirty, — it is certainly the total sum of the well-known cases. Such cases are not often met with in usual practice; however, the importance of this fact is very great. Its very exaggeration allows us better to interpret the preceding states, and contributes very efficaciously to instruct us on the theory of hysteria. Moreover, the question presents for you, as it were, a national interest. For some reason — why, I don't know — it is in America that the greatest number of remarkable cases have appeared, and it is American doctors, among them MacNish, Wood, Weir Mitchell, Dana, and quite recently one of the greatest physicians of this town, Dr. Morton Prince, who have devoted to it the most remarkable studies.

We cannot, in an elementary lesson, discuss the different forms of this phenomenon and the various theories which have been presented. I refer you for this subject to the recent book of Dr. Morton Prince, "Dissociation of a Personality," 1906, and to that of MM. B. Sidis and Goodhart, "Multiple Personality," 1905. You will find in these works all kinds of psychological discussions in which I should not like to venture. So I shall confine myself to making three typical forms known to you and to showing you in a few words in what manner these new states, which present so many interesting features, are connected with the preceding somnambulisms.

I

The type of double existences is given us by a celebrated case, more legendary than historical, published in 1831, in a work of Dr. MacNish, entitled "Philosophy of Sleep"; whose observation, it appears, dates still farther back, since it is a question of a fact observed by Mitchell and Elliot in 1816.[1] It shows you that this observation is very old and very vaguely known. This is perhaps the reason why the fact is presented to us with a simplicity which astonishes us, and which we no longer find in our observations of to-day. By much repetition the fact must have become a great deal simplified; however it may be, the following is the abridged history of her who is called the "Lady of MacNish."

A well-informed, well-bred young lady of a good constitution was suddenly seized, without previous warning, with a profound sleep, which lasted several hours longer than usual. On awaking, she had forgotten all she knew; her memory was like a *tabula rasa*, and had preserved no notion either of words or of things; it was necessary to teach her everything anew. Thus she was obliged to learn again reading, writing, ciphering. Little by little she became familiarized with the persons and things surrounding her, which were for her as if she saw them for the first time. Her progress was rapid. After a rather long time she was, without any known cause, seized with a sleep similar to that

[1] "The Medical Repository," 1816.

which had preceded her new life. On awaking, she found herself exactly in the same state in which she was before her first sleep. But she had no remembrance of anything that had passed during the interval. In a word, in the old state she was ignorant of the new state. It was thus that she called her two lives, which were continued separately and alternatively through remembrance. During more than four years this young lady presented these phenomena almost periodically. In one state or in the other, she did not remember her double character, any more than two distinct persons remember their respective natures; for instance, in the periods of her old state, she possessed all the knowledge she acquired in her childhood and youth; in her new state, she knew only what she had learned during her first sleep. If a person was presented to her in one of these states, she did not know this person in the other state, but was obliged to study and know him in both to have a thorough notion of him. And it was the same with everything. In her old state she had a very fine handwriting, the one she had always had, while in her new state her handwriting was bad, awkward, as it were, childish, because she had neither the time nor the means to perfect it. As has been said above, this succession of phenomena lasted four years, and Mrs. X. was accustomed to it, and had succeeded easily in maintaining an intercourse with her family.[1]

In connection with this case, I should like to avail

[1] In connection with this case, see Azam, "Les alterations de la personalite, in *Revue scientifique*, 1883, II, p. 616, and *id.*, "Hypnotisme et double conscience," 1893, p. 136.

myself of the opportunity to lay before you a graphic method which I once invented and of which I make great use in my lectures before the French students. This schema, I believe, enables us to represent to ourselves the various disturbances of memory in a very simple manner and makes their different varieties clearly perceptible to the eye. No doubt you are already accustomed, in your courses of medicine, to the little schemata which are made use of to represent the various lesions of the organs, and especially to represent the disturbances of sensibility. There existed no schemata of this kind for the disturbances of memory, for we have to deal with a considerable difficulty of representation. There are, indeed, in a remembrance or in an oblivion two different things which must be represented simultaneously. We must first consider the time when the remembrance exists: for instance, it is to-day that I remember the studies on double consciousness; this is the date of the appearance of the remembrance. We must also consider in a remembrance the past period to which it refers; I remember, to-day in 1906, that I already came in Boston in 1904; it is the period to which the remembrance refers. To represent these two things simultaneously, I propose to you the following schema, which is described in my book on *Nevroses et Idees fixes*, 1898, Vol. I, p. 124.

The horizontal line OX in all these Figures 2, 3, 4, 5, from the left to the right, designates the different periods of the course of life in their order of appearance. It is on this line that we inscribe the remembrances at the moment of their appearance. The vertical line OY,

from the bottom to the top, represents the same periods, but as remembrance, as representation. At each point of the horizontal line we draw a perpendicular parallel to the vertical line which represents the remembrances; its height represents the number of remembrances one

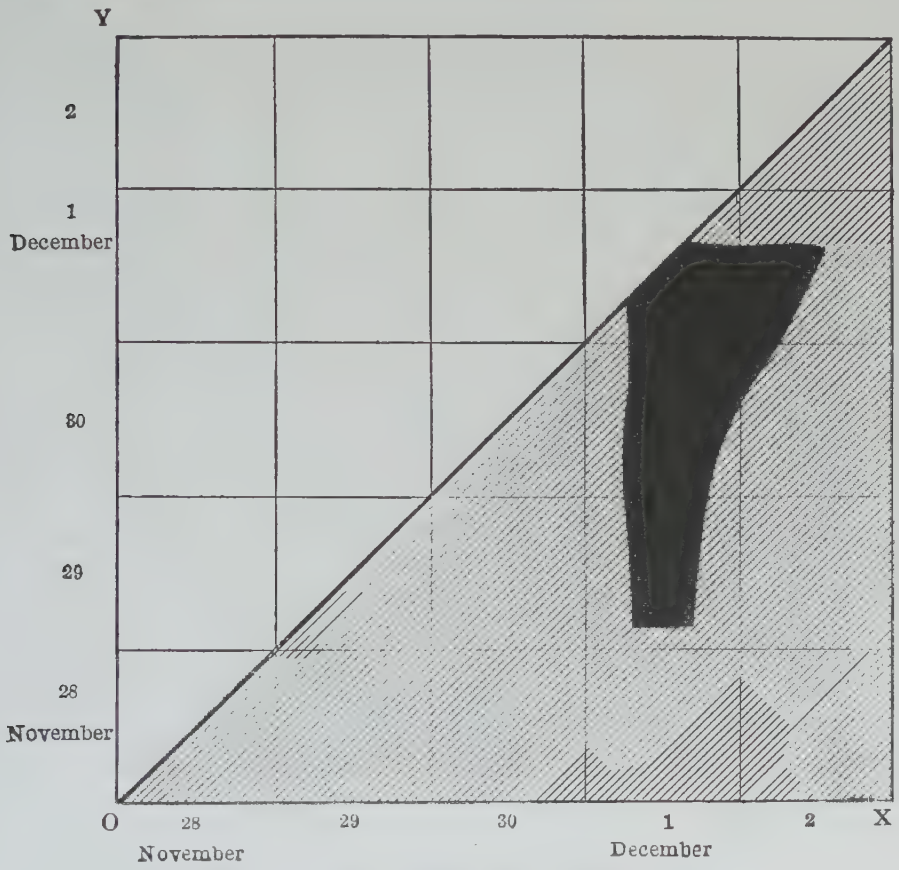


FIG. 2. — Schema of a case of retrograde amnesia: case of Kaempfen, 1835.

possesses at such or such a moment. As this height naturally increases as life passes away, and one can theoretically call up more remembrances, normal memory will be represented by this triangle, whose base is the horizontal line *OX*, and which is formed by

the diagonal drawn from the point *O*. If you have to represent oblivions, amnesias, you will mark a black spot above the point representing the date at which this accident took place, and the height of this black spot will be determined by the parallel line which meets on the vertical the forgotten remembrance. This figure, not very complicated, upon the whole, allows us to represent the different amnesias in a very clear and striking manner.

As examples, and in order to accustom your eyes to these schemata, which are very useful in clinical studies, I put before you various figures representing the more usual forms of amnesias which you will meet with in your practice. You have already studied with your masters of neurology and psychiatry the retrograde amnesia (Figure 2) which, beginning after some physical or moral shock, takes away all the memories of the preceding time; you know, too, the continuous amnesia (Figure 3), wiping out the remembrances of events as life goes on, continuously.[1] You see that the general aspect of the schema is quite different, and that it puts into evidence the differences between the two diseases of the memory.

We can now apply this method of representation to the double existences we were studying. In Figure 4 I have drawn a figure representing the case of the "Lady of MacNish," and you see that it is very characteristic. It is a kind of draught-board, in which black and white squares alternate very exactly. You will remark, in

[1] See "L'amnesie continue," in *Nevroses et Idees fixes*, 1898, I, p. 109.

fact, that in this singular history the oblivions and remembrances alternate in the same way very regularly. In the state called state No. 1, the "Lady of Mac-Nish" does not remember the state No. 2 at all; in the state No. 2 she does not remember the state No. 1

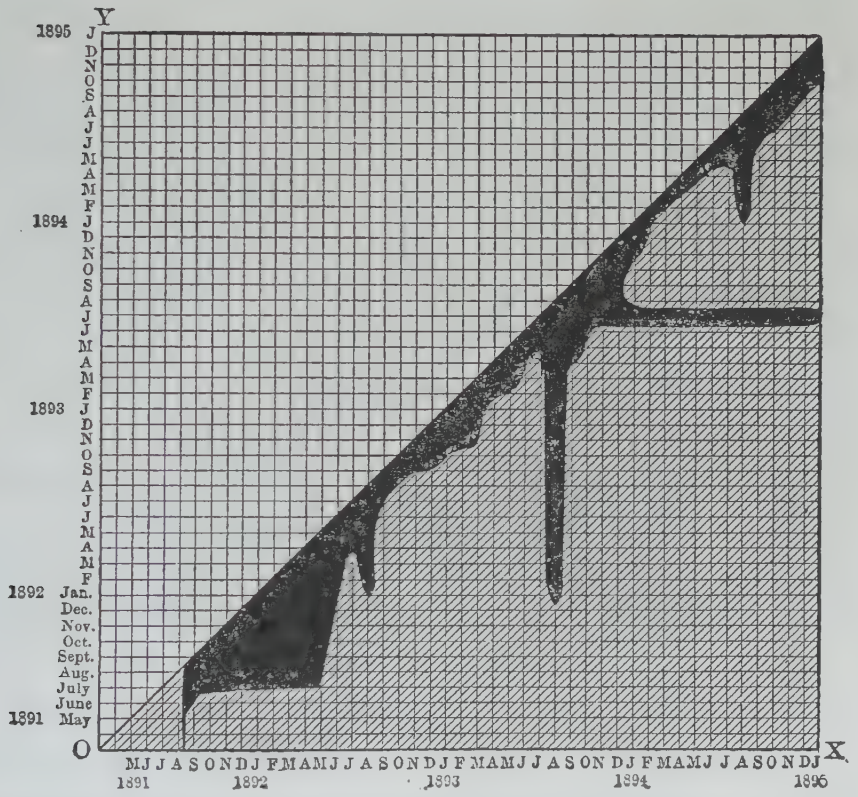


FIG. 3. — This scheme represents all the modifications of the memory during four years of a patient, Mrs. D., presenting *continuous amnesia* after a shock of emotion.

at all. When she comes back to the state No. 1, she remembers only this state and nothing more. It is the same when she comes back to the state No. 2. There is in the disease a perfect alternation which the schema illustrates very well by its draught-board, and which is quite peculiar to this type of patients. I have pro-

posed to call this form of somnambulisms, "reciprocal somnambulisms." [1]

Double existences of such a simple form are very rare. It very seldom occurs that the subject in his abnormal existence has entirely forgotten his normal existence, and that in the latter he has likewise entirely forgotten the other period. This absolute division of life into two alternating periods which do not know each other at all is quite exceptional: we can connect only a small number of cases with the type of the "Lady of MacNish." The case of Dana is perhaps of this kind, but at all events the disease lasted a much shorter time. Two cases of Charcot, that of Marguerite D. and that of Habillon, which you will find published in the last two volumes of his works, and which have been reported by M. Guinon, approach this form. But certainly the finest modern case analogous to that of MacNish appears to me to be the history of Mary Reynolds, published by Dr. Weir Mitchell in 1888.[2]

Mary Reynolds was an intelligent, calm child, rather reserved and melancholy, but of apparent good health. The nervous disturbances began towards the age of eighteen with a rather protracted syncope, after which she remained for five or six weeks blind and deaf. The sense of hearing returned all at once, the sense of sight

[1] The reciprocal somnambulisms in "L'etat mental des Hysteriques," 1894, II, p. 197; "The Mental State of Hystericals," translation by Mrs. C. R. Corson, New York, G. P. Purnam's Sons, 1901, p. 419.

[2] S. Weir Mitchell, "Mary Reynolds, a Case of Double Consciousness," in *The Transactions of the College of Physicians of Philadelphia*, April 4, 1888.

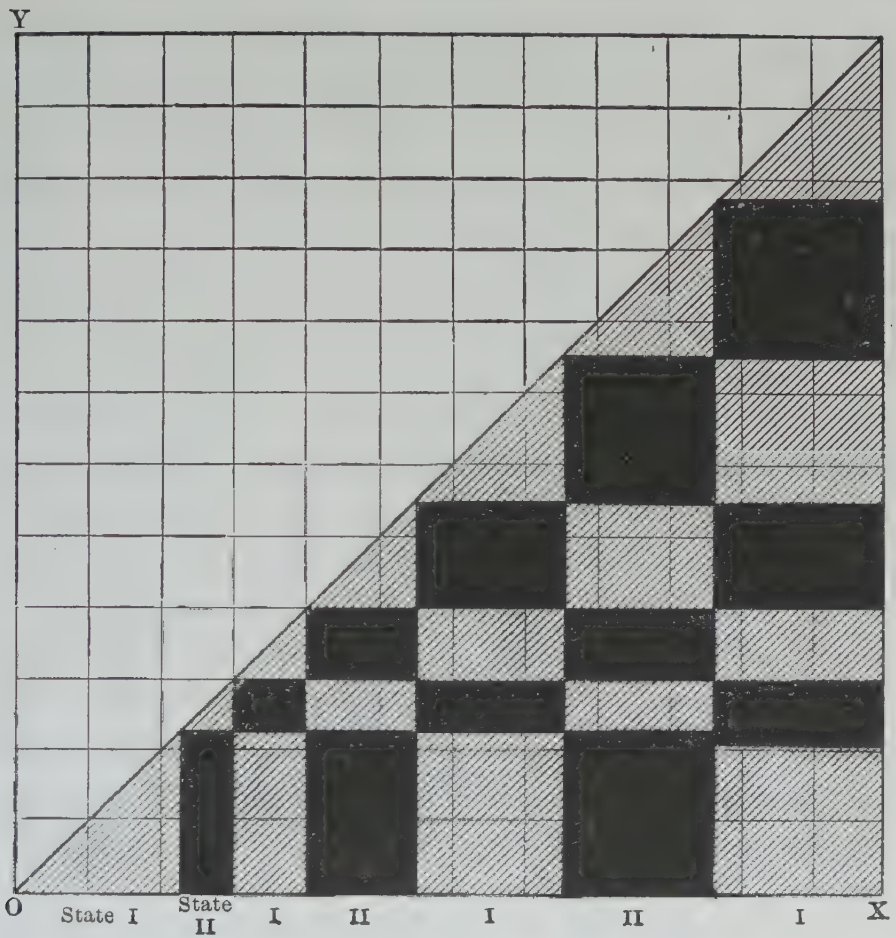


FIG. 4. — Schema of the reciprocal somnambulisms in the case of the "Lady of MacNish."

returned gradually and completely. We need not dwell now on these sensorial disturbances, which we shall study later on. After a second syncope, which lasted from eighteen to twenty hours, she awoke, apparently with all her senses, but she had forgotten all her former life and all the knowledge previously acquired; nothing was left her but the power of instinctively pronouncing, like a child, a few words, without understanding them. She was obliged to learn everything anew. But it

must be acknowledged that her education was rapid, since, after a few weeks, she could again speak, read, and write. It was noticed that she learned again to write in an odd manner: she handled her pen awkwardly, and began to copy from the right to the left, after the manner of the Orientals. She always kept, in this second existence, an inverted handwriting very different from her ordinary handwriting In this second existence her character was quite transformed: she had become lively, cheerful, was no longer afraid of anything, wandered about the woods, played with dangerous animals; she dealt shrewdly with and mocked at the persons who wanted to direct her, and, in reality, no longer obeyed anybody. After about ten weeks she again had one of those strange sleeps, and awoke of herself in the first state. She no longer had any remembrance of the period which had just elapsed, but she recovered her previous knowledge and character. She was slower and more melancholy than ever.

After some time, the same accident caused her to return to the state which appeared to be the second. These transitions often took place in the night during her natural sleep, sometimes in the daytime, and they were often painful. The subject was, as it were, frightened by a kind of feeling of death, "as if I were never to return into this world." When the second existence reappeared, Mary Reynolds was again exactly in the state in which she had been at the end of the corresponding period, with the same acquired knowledge and the same remembrances; but she again forgot everything when she returned to the state No. 1.

About the age of thirty-five or thirty-six, the state called No. 2 became definitively predominant. It was reproduced more often, lasted longer, and at length became in a manner definitive, since she remained twenty-five years in this state. The author remarks that, at the end of her life, there seemed to be a kind of confusion between the two states; at least the state No. 2, which had become preponderant, expanded, and seemed vaguely to acquire remembrances belonging to the state No. 1. "It seemed to her that she had, as it were, an obscure, dream-like idea of a shadowy past which she could not quite grasp."

You see that, in general, the observation of Mary Reynolds is the one which most approaches that of the "Lady of MacNish," and which best presents the two existences quite independent of each other. However, even in this case, you remark, at the end of life, a tendency of the state No. 2 to encroach upon state No. 1. This will be found to be the essential characteristic of another form of double existence much more common than the first.

II

I have given to this new form the name of *dominating somnambulism*, because one of its essential features is that one of the states dominates the other. In this state, the subject is more active, more lively, more intelligent than in the other, and what is particularly important, the memory, during this state, is much more extended than in the other.

If America can boast of having presented in the person of the "Lady of MacNish" and in that of Mary Reynolds the finest examples of the first form, the history of Felida X. gives now to France an unquestionable superiority. Allow me to make you acquainted with Felida. She is a very remarkable personage who has played a rather important part in the history of ideas. Do not forget that this humble person was the educator of Taine and Ribot. Her history was the great argument of which the positivist psychologists made use at the time of the heroic struggles against the spiritualistic dogmatism of Cousin's school. But for Felida, it is not certain that there would be a professorship of psychology at the College de France, and that I should be here, speaking to you of the mental state of hystericals. It is a physician of Bordeaux who has attached his name to the history of Felida: Azam reported this astonishing history first at the "Society of Surgery," then at the "Academy of Medicine," in January, 1860. He entitled his communication, "Note on Nervous Sleep or Hypnotism," and spoke of this case in connection with the discussion of the existence of an abnormal sleep during which it would be possible to operate without pain. And this communication, thus incidentally made, was to revolutionize psychology in fifty years. Subsequent to that time, Azam understood better the interest and success of his observation; he published various memoirs, and even books on this subject, in 1866, 1876, 1877, 1883, 1890. As I told you, first Taine, in his book on "Intelligence," then Ribot, in his "Diseases of Memory," took possession

of this history, which has gone round the world, and to-day there is a whole library written about this poor woman.

When Azam first knew Felida in 1858, she was already fifteen years old, and had already been ill for three years since the appearance of puberty. This frequently occurs in hysteria, as you will see later on. She had all kinds of hysteric accidents, attacks of motor agitation, disturbances of alimentation, which we need not examine now. All kinds of sufferings had changed her character for the worse; she was a reserved, melancholy, and timid person. She had a great number of disturbances of sensibility, consisting both of pains and diffuse insensibilities.

Among all these miseries, there appeared from time to time, rather infrequently at the beginning, another very strange phenomenon. She seemed to faint away for a very few minutes; it is the transition we have already remarked in most somnambulisms. Then she would wake up suddenly, become gay and active, and bustle about, without any anxiety or pain; she no longer had those painful sensations or those insensibilities which troubled her before, and she was in much better health than in the preceding period. But let us immediately remark that in this apparently new state she by no means presented the characteristic disturbance of the "Lady of MacNish" and of Mary Reynolds. She had nothing to learn again, because she had forgotten nothing: she preserved a very clear remembrance of all her former life, of all the sufferings she had undergone, and of all she had learned before.

So everything went quite well; but this state of comfort lasted but a short time. After one to three hours, she had a new syncope, and then awoke in the preceding state, considered as normal, which we may call, according to Azam's convention, the prime state. On returning to this state, she resumed again all her infirmities, and the slow, melancholy character which was her usual one. But there was now one phenomenon more: she had quite forgotten the few preceding hours filled by the state No. 2, or the lively state. All this period was for her as if it did not exist.

This caused no great inconvenience at that time, since the state called No. 2 occurred only from time to time and lasted an hour or two. But, little by little, this state developed singularly; it lasted for hours and days, and as the subject was now much more active, it was filled with all kinds of serious incidents. You will read in Azam the strange narrative of that consultation about the first pregnancy of Felida. The poor girl, during her period of excitation and gayety, had given herself up to a young man who was to be her husband. The awakening occurred shortly afterwards, and did not leave her the least remembrance of this incident. As her health was impaired, and her abdomen grew bigger, she naïvely went to consult M. Azam about the strange disturbances in her health. "The pregnancy was evident," says Azam, "but I dared not make it known to her." Some time after, the state No. 2 returned, and Felida, addressing herself to the physician, laughingly apologized for her preceding consultation, for she now knew very well what was the matter.

During the greater part of her life, these two periods alternated, and it was only in her old age that one of the two periods, the second, — that is to say the better one, — during which the subject was more active and had a total memory, encroached upon the first and filled almost the whole of her life. Henceforth Felida seldom remained three or four days in her former state, called normal; but then her life was intolerable, for she had forgotten three-quarters of her existence, and this gave rise to the most comical situations. She feared to pass for mad, and in her anguish hid herself till a new syncope restored her to her better state, which was now her habitual one.

Such are the chief features of this history, which has become celebrated. You may easily see wherein it differs from the preceding observations. The schematic figure (Figure 5), which you can now understand, gives you quite a characteristic image. It is no longer a draught-board on which the periods of oblivion regularly alternate with the periods of remembrance. You see regularly entire light-coloured stripes, which are broader and broader as life advances, in which there is no black spot; they are the periods of the state No. 2, during which the memory extends over the whole of life without any amnesia. On the contrary, in the intercalary stripes representing the state No. 1, you see series of black spots representing more and more extended amnesias affecting the periods of life which were filled by the state No. 2. This figure clearly shows you that the two somnambulisms are not equal, that one is superior to the other, especially as regards the memory;

this is what justifies the name of *dominating somnambulisms*[1] which I have given to these cases.

If the cases of the first kind, grouped around the "Lady of MacNish," are rare, this is not true of those

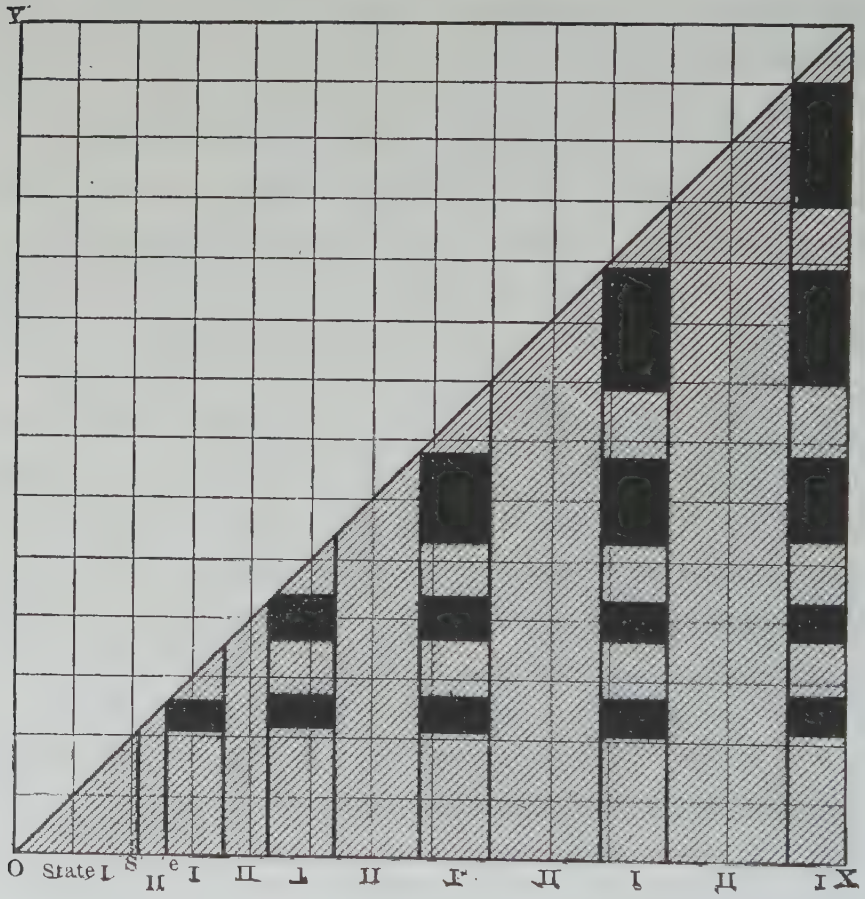


FIG. 5. — Schema of the dominating somnambulism in the case of Felida X.

of the second group, which have Felida for type; the case of Ladame, that of Verriest (1888), of Bonamaison (1890), of Dufay (1893), and many others could be described from the same model. It is of no use to

[1] "The Mental State of Hystericals," translation, p. 422.

dwell upon this. These cases do not present any really new psychological phenomena.

But it would be well to form a third group, which might be called the group of complex cases, in which some celebrated observations ought to be placed. I allude to the complicated cases of patients who have not two forms of existence, but a very great number of forms of existence, as many as nine or ten. These different psychological states offer very various relations with one another; sometimes they are quite independent of one another and present a simply reciprocal memory; the subject only finds again the remembrances of the state No. 1 when he comes back to the state No. 1, but he by no means remembers this state when he is in the state No. 2 or in the state No. 4. But such patients have besides, and at the same time, other states obeying another rule. For instance, they are apt to enter into a particular state, which we shall call No. 3 in which they not only remember the other periods of the state No. 3, but also remember the periods of the state No. 1 and of the state No. 2. In a word, they have reciprocal somnambulisms and dominating somnambulisms.

One of the most remarkable cases published in France is that of Louis Vivet, studied from 1882 to 1889 by many authors, by Legrand du Saulle, Voisin, Mabille and Ramadier, Bourru and Burot. This boy has six different existences. Each of them is characterized, first, by modifications of the memory affecting now one period, now another; secondly, by modifications of character; in one state he is gentle and industrious,

in another he is lazy and irascible; thirdly, by modifications of sensibility and of motion; in one state he is insensible, and paralyzed in his left side; in another he is paralyzed in his right side; in a third he is paraplegic, etc. An English author, Mr. Arthur Myers, the brother of the well-known psychologist, in an article in the *Journal of Mental Science*, January, 1886, tried to group in a table these four modifications, characterizing each state. The most curious fact of this state is that one can, by acting on this third character, bring about the corresponding modifications of the other two. If one cures the paralysis of his two legs, one causes him to enter into the state in which he has all his sensations and movements, and then one sees the character and state of memory corresponding to this period reappear. But these facts are especially interesting from the point of view of the artificial reproduction of somnambulisms and even of second existences. We need not dwell on them to-day.

After having reported this French case, let us consider some very remarkable American observations. One of the most astonishing observations, whose scientific value, unfortunately, I can hardly appreciate, is that which was published in 1894 under the rather strange title of "Mollie Fancher, the Brooklyn enigma; an authentic statement of facts in the life of Mary J. Fancher, the psychological marvel of the nineteenth century; unimpeachable testimony by many witnesses, by Abraham H. Daily, 1894." The history is strangely related; you feel in it a kind of mystic admiration for the subject, an exaggerated seeking after surprising and

supranormal phenomena, which of course inspires you with some fear as to the way in which the observation has been conducted; it nevertheless contains many very remarkable and interesting facts. Mollie Fancher, who seems to have had all possible hysterical accidents, attacks, terrible contractures lasting for long years, more or less complete blindness, etc., above all presented all the forms of somnambulism, from the simplest to the most complicated ones. There are in her at least five persons, who have very poetical pet names: Sunbeam, Idol, Rosebud, Pearl, Ruby, each one with her remembrances and her character. The complication of this case is very amusing.

Lastly, we have to point out the last and most remarkable of the observations of this kind, the observation of Miss Beauchamp, by Dr. Morton Prince, one of the physicians of Boston who have most interested themselves in the development of pathological psychology, and who devoted years of work to the observation of this complicated and interesting case. We cannot here enter into analysis of these complex cases which, moreover, are but various combinations and forms of the two simple forms we have studied. In these complex cases a new influence usually makes itself felt which complicates matters a great deal. I mean the influence of the observer himself, who, in the end, knows his subject too well and is too well known to him. Whatever precautions one may take, the ideas of the observer in the end influence the development of the somnambulisms of the subject, and give it an artificial complication. However it may be, I

must add the study of these complex cases to the two simple forms I have pointed out, in order to make you understand all the developments which may be taken by this strange phenomenon of multiplex personality in hystericals.

III

We cannot enter into the psychological study of all the problems raised by the double existences of hystericals. Besides, I have pointed out to you some works published in this very city, in which you would find these discussions very well conducted. I only wish, before concluding this lecture, to give you a few indications as to the direction which, in my opinion, these studies should take, and as to a general conception of these apparently mysterious phenomena.

Let us take up one more observation of a double personality, which differs from the preceding ones only by a singular slight detail; namely, that it was, for a great part, produced artificially. Long ago, in 1887, a young woman of twenty, whose name was Marceline, entered the hospital in a lamentable state. For several months past she had not taken any food; first, because she obstinately refused to eat, then because she immediately vomited any food or drink one forced her to swallow. Besides, she no longer had any function of evacuation; she was incapable of urinating spontaneously, and sounding alone could cause her to discharge a few drops of urine. In these conditions, this young woman, who had reached the last stage of emaciation, seemed to have but a breath of life left;

she remained constantly lying in her bed, being incapable of standing. Her mental activity was as much reduced as her physical activity; she was completely insensible on the whole surface of her skin and on all her mucous membranes; she heard very badly, and saw but exceedingly little. Though she looked intelligent, she replied with great indifference to the questions put to her, and seemed to be in a serious state of stupefaction. As we did not succeed in nourishing her otherwise, we had to try the effect of hypnotic practice.

After some attempts, we easily caused her to enter into a singular state, which appeared momentary and artificial, but differed altogether from the habitual state in which we had constantly seen her since her entrance into the hospital. She looked quite transformed physically and morally. She was now capable of moving, she accepted any food, and had no longer any vomiting. Lastly, she urinated spontaneously, without difficulty. On the other hand, she had become sensitive over her entire body, and could hear and see perfectly; she expressed herself much better, with more vivacity, and showed a complete memory of all her anterior life. After having nourished her in this new state, we thought it necessary to awaken her, since this state was considered artificial. She immediately fell back into her preceding state. Inert, insensible, unable to eat or urinate, she simply presented one more disturbance; namely, according to the law of somnambulisms, which you know, she had quite forgotten what had happened during the preceding period.

Nevertheless, thanks to these artificial somnambulisms, we were able to nourish her and cause her to recover her strength. But it was always impossible to make her eat in the period considered normal, which we always brought back by awakening her. So that, tired of thus putting her to sleep at each meal, which was very long, we left her for whole days in the artificial state. The only result was apparently a great advantage, since all day she ate well, urinated completely, and presented more sensibility, memory, and activity. One day her parents, finding her in this fine artificial state, considered her cured, and took her out of the hospital.

Everything went well during the first days; but, after a few weeks, on the occasion of her menstrual period, she experienced a kind of upsetting, and awoke spontaneously, that is to say, she suddenly returned to the state of depression and stupefaction from which we had drawn her, but she presented, in addition, a forgetfulness bearing, this time, on whole weeks. She was very much bewildered at finding herself in her house without understanding how she had left the hospital, for she did not remember the events of the preceding days. Besides, she again refused to eat, and could not urinate. Marceline was brought back to me, and, in the presence of all these disturbances, which were well known to me, I could do nothing else but put her to sleep again, or rather bring her back to her artificial state.

Well, gentlemen, things continued in this way for fifteen years. Marceline would come to me in order to be

put to sleep, enter into her alert state, and then go away very happy, with complete activity, sensibility, and memory. She would remain thus for a few weeks; then, either slowly or suddenly, in consequence of some emotion, fall back into her numbness, return to the state we had considered primitive and natural, with the same visceral disturbances. The forgetfulness now extended over whole years, and disturbed her existence completely. She would hasten to come to me to get herself transformed again. Things continued thus for years together, till the death of the poor girl, who succumbed to pulmonary tuberculosis.

How are the two states of Marceline to be explained? You see they are quite like what we have just described in connection with the dominant somnambulisms of Felida. The latter also had two states, one melancholy and incomplete, in which she had great oblivions; the other, alert, in which she found again all her sensibility and memory. Marceline resembles her so much that I have already proposed to call her an artificial Felida. We ought, then, to apply to her the conventions proposed by M. Azam, as well as by all the authors, to designate these two states. We ought to say that the state No. 1 is the state of depression in which we found her at the beginning and which looked normal; that the state No. 2, a superadded or artificial state, is the alert state with complete memory.

Well, these denominations seem to me quite incorrect when applied to this case, which I followed so long. It is absurd to call state No. 1, — a state of mental depression incompatible with life, — a natural state; it is un-

likely that this young woman has always been, from the first, in such a state. In reality, it is false: she began by having in her girlhood, before puberty, all these sensibilities, all these functions at her disposal. She ate and digested very well, and urinated spontaneously. This is the real state No. 1. There is no doubt on this point. The state in which we saw her in the hospital, with all her disturbances and insensibilities, is an abnormal state brought on by illness, by hysteria, which had evolved since her puberty. It is the state No. 2.

But what shall we do, then, with the state obtained through hypnotism, which was produced artificially? Is it a state No. 3? By no means. In this state her functions were normal; she recovered the sensibility and memory she had formerly had. I see no reason why we should distinguish this state from the natural state of her childhood, which we called state No. 1. It is simply a momentary cure, which we brought about through processes of artificial excitation. And when she falls back into the state No. 2 it is simply because the disease begins again.

All this history may be represented by the following diagram. Slowly, without its being perceived, this young girl grew worse every day; she had gradually lost sensibility and memory. We may represent this stage by a line which descends well below the line *AB* of normal activity (Figure 6). When she has been hypnotized in *C*, she rises again to a state of almost normal activity in *D*. Through the effect of illness, she gradually redescends. At first she seems to awaken a little

as soon as you leave her, and forgets what you have just now told her, *E*. Then, two days after, she wakes again, *F*, that is to say, she experiences a fall into a state of hysterical anesthesia and amnesia still deeper than before, *G*; she forgets the two preceding days.

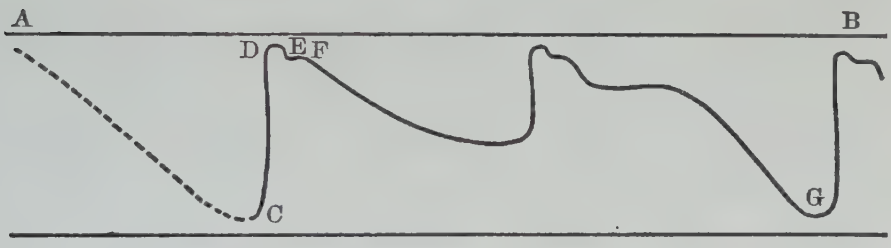


Fig. 6. — Diagram of the oscillations of mental level in the case of Marceline.

Then she goes down very slowly. If you let her fall again by an emotion, for instance, there will be complete amnesia of the whole preceding period. If you excite her, there will be, on the contrary, a psychological state far more complete, and a total remembrance of the preceding periods. It is these falls, these returns to anesthesia, which give to the normal periods the aspects of somnambulisms.[1]

I think it is absolutely the same with all such cases, that everything has been confused through false denominations. Felida also had in her childhood a state No. 1, which now no longer exists, except in her periods of alert state, improperly called state No. 2. It has been noticed with astonishment that, at the end of her life, this state exists almost alone; it is simply because the hysteria is cured, and she returns to the normal state of her girlhood, which she ought always

[1] "The Mental State of Hystericals," translation, p. 449.

to have kept. There is nothing abnormal but the state of depression with amnesia, which settled gradually after her puberty, and which was mistaken for a state No. 1, because it had lasted for a long time when the subject was observed.

In this view things become somewhat clearer; the essential phenomenon that, in my opinion, is at the basis of these double existences, is a kind of *oscillation of mental activity*, which falls and rises suddenly. These sudden changes, without sufficient transition, bring about two different states of activity: the one higher, with a particular exercise of all the senses and functions; the other lower, with a great reduction of all the cerebral functions. These two states separate from each other; they cease to be connected together, as with normal individuals, through gradations and remembrances. They become isolated from each other, and form these two separate existences. Here, again, there is a mental dissociation more complicated than the preceding ones. There is dissociation, not only of an idea, not only of a feeling, but of one mental state of activity.

LECTURE V

CONVULSIVE ATTACKS, FITS OF SLEEP, ARTIFICIAL SOMNAMBULISMS

A great number of convulsive attacks and of fits of sleep are nothing but imperfect somnambulisms — The association of ideas in the hysterogenic points — The diagnosis of hysterical and epileptical fits — The crisis of emotional manifestation — The different fits of sleep, the lethargies — The perseverance of thought during this sleep, the crisis of revery — The artificial reproduction of hysteric accidents, of attacks, of fits of sleep — Artificial somnambulism or hypnotism — The hypnogenic points — The hypnotic state as a reproduction of hysteric somnambulism

All the preceding examples — the study of monoideic and polyideic somnambulisms, the study of fugues and of double existences — showed you the considerable importance assumed by somnambulisms in hysteric neurosis. We should still have many forms of the same phenomenon to consider. But to-day I wish only to dwell on certain elementary and, in some manner, degraded forms of somnambulism, because they are common, because they are to be met with every day, and because it is necessary, in order to understand them, to be able to connect them with the more typical somnambulism, of which they are only inferior forms. You will understand the interest of this study, if you notice

that it first applies to two phenomena very important in practice, — convulsive attacks and fits of sleep.

I hasten to tell you that I do not vaguely connect all hysteric attacks and all fits of sleep with phenomena of somnambulism. The words "attack" and "sleep" are vague words, borrowed rather from the vulgar than from scientific language, and very varied phenomena are ranged under them. You will soon see, on the occasion of motor agitations, that the hysteric attack is often constituted by an ensemble of tics, of choreic movements, connected together in a certain manner. Sometimes fits of sleep are simply paralytic phenomena; the subject is incapable of moving, but hears and understands very well and has no intellectual disturbance. So we shall meet later on with many other forms of attacks and fits of sleep, but to-day we are to study one of the most essential forms, in which these two accidents are nothing but particular aspects of certain imperfect somnambulisms.

I

Convulsive attacks, which we have first to attend to, are exceedingly frequent phenomena; they were noted even by the philosophers and doctors of ancient Greece. It is this phenomenon that the Middle Ages and the Renaissance reproduced in the documents relating to exorcisms. Modern authors, such as Briquet, state in their statistics that three-quarters of their patients have attacks.

At first sight, the patients, who seem to have become

unconscious, and writhe in disorderly convulsions, appear to be very different from the somnambulists we have just studied. Complete somnambulism was evidently characterized by a great number of intelligent manifestations; the subject expressed his idea, his dream, by his adjusted movements, which usually are to our mind the expression of reasonable thoughts. The first and clearest of these expressions was speech, and we had no great merit in guessing the subject of such dreams, since the patient expressed it himself by language. When he did not speak, he had expressions of the physiognomy, attitudes, and especially acts, the interpretation of which was very clear; he was seen to get up, to walk, to seek for objects in a drawer, to make the gesture of holding a revolver and pulling the trigger, to struggle with phantoms, etc. In a word, the outer expression of the somnambulic idea was as clear as possible. There is nothing of the kind in convulsive attacks, in which the subject seems to writhe in great, irregular, apparently meaningless movements.

Yet it is easy to prove that, from many points of view, these convulsive attacks approach somnambulisms. These accidents, though apparently constituted by uncoordinated movements, have the same moral causes as somnambulisms; they begin, like them, on the occasion of particularly affecting events, genital perturbations, sorrows, fears, etc. A man begins to have crises of hysteria because he has seen his son fall from a scaffolding and die before him; many girls or women begin to have attacks on the occasion of the

death of a beloved person; in about ten observations, the cause of the first fit is a conflagration, a petroleum lamp setting the subject's dress on fire; in others, it is a fall from a tram car or from a bicycle, a fight with comrades, heart-grief, reverses of fortune, etc. I wish to dwell only on one story, that of the woman with the dog, which affords a fine example of attacks displaying the form of imperfect somnambulism, joined with tics, to which we shall allude later on. This lady, forty-three years old, who had always been impressionable, of course, was already very much upset by the death of a very dear friend; she had kept only one souvenir from him, a very precious souvenir, an old dog. Now, two years after his master's death, the dog died, in his turn, on a carpet. This lady, in despair, lay down on the carpet on which the dog had died, and remained there for sixty days without consenting to accept any food or to take any care of herself. From that time she began to have terrible fits of hysteria, which assumed many forms. You see by this example that the starting-point of convulsive attacks is the same as that of the preceding somnambulisms.

Let us go one step farther and consider the occasional cause that determines the appearance of each new attack; it is easy to see that here, again, moral causes play an important part. It is true the patient maintains that the fit occurs irregularly, without her knowing why, and that it is brought on solely by physical causes. There may be some truth in the remark that the time which has elapsed since the last attack plays a great part. When patients have just had their fit

of somnambulism or convulsions, they cannot always begin a new attack immediately. They seem to be modified, and to have become less sensitive to the various moral impressions; a certain time must elapse — two days for one, a week or a month for another — before they become very impressionable and capable of recommencing the same phenomenon. This is true; we meet here with a very interesting periodical oscillation, which we shall have to take into account at the end of this course of lectures. But besides this general predisposition, it is none the less true that a thousand accidental circumstances bring about the appearance of the fit. First of all, slight exterior phenomena may produce this effect. The sight of a flame, sometimes of a match only, brings about the fit with those subjects who have been affected by a conflagration; any cry, or name, or sentence, will call it back with others. Our woman with the dog is admirable in this respect: it is enough that a dog barks in the street, she sees a cat pass by, the name of one of the animals is pronounced, or even certain words are pronounced, the use of which she absolutely forbids, as the words "love," "affection," "happiness," etc. It is enough that a date on the calendar be mentioned before her, for the fear of remembering a certain date has caused her to forbid all possible dates. The least thing is enough to bring about an endless fit, in which convulsions and howlings mingle together for fifteen or twenty hours. Is it not obvious that, in all such cases, there is an association of ideas between the dreaded perception and the remembrances which bring on the fit as

well as the somnambulism? The different terms of these systems of ideas are connected together in such a manner that they mathematically call up one another.

You would perhaps find it more difficult to recognize the same law if you considered attacks, the starting-point of which seems to be the touch or excitation of a point of the subject's body. You know that formerly great importance was attributed to such points, which were called *hysterogenic points*. Charcot and Pitres wrote a long disquisition about them, which nowadays seems to contain many errors. It was admitted that the fit began with a pain or a strange sensation situated at such or such a point of the body; the most frequent points with women were the lower region of the abdomen, called the ovarian region, on either side. Pains at this point at the moment of the fit were so frequent that they even determined the theories of the ancients on hysteria. You remember the absurd story invented by Plato, which spread all over the world, obnubilating the minds of physicians for centuries, and casting a kind of shame on all such patients. It was, he said, the overexcited matrix which required satisfaction, and as this satisfaction was not obtained, it ascended through the body as far as the throat of the patients and choked them. In fact, this sensation of uneasiness, which often begins in the lower part of the abdomen, seems to ascend and to spread to other organs. For instance, it very often spreads to the epigastrium, to the breasts, then to the throat. There it assumes rather an interesting form, which was for a very long time considered as quite characteristic of hysteria.

The patient has the sensation of too big an object, as it were, a ball, rising in her throat and choking her. She makes an effort either to swallow or to expel this big object. Other points and sensations may intervene, irregularly situated in the breast, shoulders, eyes, or head, and they seem to depend on purely physical phenomena.

Do not misunderstand the nature of such points. First, they never correspond to real organic lesions, or, at least, if there are any lesions, they play no part in hysteria, properly so-called. Then, in spite of appearances, try to realize thoroughly that these sensations are moral, not physical, and that they also depend on the ideas and emotions of the subject. For you must not forget that the different regions of our body participate in all the events of our life and in all our sentiments. Let us consider two individuals, both of them wounded in the shoulder, one by an elevator, the other by an omnibus. These wounds have long been cured, but you can easily understand that the remembrance of a sensation in the shoulder, that even the idea of the shoulder, is a part of the remembrance of the accident; it is enough that you touch one of these patients on the shoulder for this peculiar sensation to remind him of his accident and determine the crisis. The idea of consumption, the fear of the phthisis, is accompanied by a certain painful sensation in the summit of the left lung, on the occasion of which it began. The same sensation located in this spot will be the starting-point of the fit. In amorous emotions, unless we have to deal with pure spirits, there are genital sensations with

a swelling of the region. What difficulty is there in understanding that in all these emotions of regret, of love, of remorse, this image of a physical sensation intervenes and plays the part of a starting-point? Add to this the innumerable associations of ideas determined by the habits of the patient or the questions of the physician. And do not forget that those pretended hysterogenic points are merely spots in which certain peculiar sensations easily arise, associated with the remembrance of an affecting event.

Let us now pass on to the end of the fit, and you will meet with one more essential phenomenon of somnambulism: the subject, after more or less protracted struggling, seems to wake up all at once or gradually, sets her dress to rights, and, almost without any difficulty, gets up again and resumes her occupations. Here is to be noticed a great medical fact; namely, that the hysteric fit does not seem to bring about a great physical disturbance, as the epileptic fit does. The subject is not exhausted; she has not the stupefied, haggard aspect of an awaking epileptic, nor the irresistible need of sleep which characterizes the comitial fit. Our hysteric patient, after howling for several hours, feels rather comfortable; she experiences, as it were, a relaxation, and declares she is much better than before the fit. Another characteristic phenomenon is that she attaches no importance to what has happened; she is not in the least ashamed of her cries, her indecent attitudes, the disorder of her acts. She seems to have forgotten everything, and in truth remembers only the facts previous to the fit; all that has occurred after

the sensations of choking and the ascent of the ball no longer exists for her. This oblivion is very important; no doubt it is more or less profound, according as the hysteria is more or less characterized, but it is a part of the disease. Beware of crises of violent agitation in which there is no loss of consciousness and of which the subject keeps an accurate remembrance. Do not inconsiderately call that hysteria; it is nearly always something else. In the most favourable cases, you have to deal with the crises of agitation of the psychasthenic. Unfortunately, you have often to deal with mental disturbances the diagnosis of which is more or less easy. I would only insist on the fact that our fit of real hysteria ends with an oblivion like somnambulism itself.

Let us now return to the facts constituting the fit itself. They are first meaningless movements. The patients grow stiff, then seem to try still to exaggerate this extension by throwing back the head, by raising the abdomen, by "making a bridge," according to the usual expression; the head is agitated in one direction or the other, the eyes closed, or open with an expression of terror, the mouth distorted. Now the patients grind their teeth, but without biting their tongue; now they open their mouth and utter piercing cries in every tone. The arms are agitated in every direction; they strike at haphazard on the surrounding objects or on the breast; the fists alternately close or open. The breathing is loud, irregular, the heart beats quickly, the face is congested, without, however, being violet-hued, as in the epileptic fit. It all seems very disorderly and unintelligible.

There is, however, a comparison which at once comes to our mind, and which is very clearly indicated in the old work of Briquet. "A fit of simple hysteria," he said, "is nothing but the exact repetition of the disturbances by which vivid and painful moral impressions are manifested.[1] . . . I choose as an example what happens to a somewhat impressionable woman experiencing a sudden and vivid impression. This woman at once has constriction in the epigastrium, she feels some difficulty in breathing; something rises to her throat and chokes her; lastly, she feels in all her limbs an uneasiness which causes them to fall, or she feels an agitation, a need of movement which causes her to contract her muscles. This is the exact model of the most common hysteric accident, of the most usual hysteric spasm." [2]

This general conception applies very well to the greater part of convulsive fits. It is easy to verify the assertion that this crisis is in fact an ensemble of emotional manifestations. In many cases it is even possible to distinguish and recognize the particular emotion thus expressed. Certain patients plainly manifest anger; they strike, scratch, bite, and their cries are menacing; others evidently have crises of grief and despair, their tears and moanings have quite another meaning than the cries of the former. It is not very difficult to recognize erotic crises with the latter, for they play certain scenes in a remarkable manner. With the former, on the contrary, much oftener you

[1] Briquet, "Traite de l'hysterie," 1859, p. 397.
[2] Id., ib., p. 4.

have crises of fear; the bewildered expression of the eyes, the movements of defence of the arms stretched forward, the drawing back of the body, are quite characteristic.

Besides, nearly all these patients, though they do not speak clearly, as in somnambulisms, mingle some words with their cries, and you easily distinguish the one who calls "Gaston" or "Oscar," with tender words, and the one who howls, "Mamma, help!" In many cases, indeed, the phenomenon may be said to be intermediate; the subject speaks a little more, her movements are less incoordinate and somewhat more expressive. These phenomena are almost somnambulisms, analogous to the preceding ones, but less perfect. The crisis of the woman with the dog unquestionably belongs to this mixed type. For long hours together the following phenomena mingle together and succeed one another; first, sobs, tears streaming down her face, cries of despair, great movements of the arms to strike her breast and tear her hair, then declamations about fate, which strikes without a reason, which strikes even the best without their having deserved their lot, then recitals of mournful passages borrowed from such poets as Lamartine or Musset:—

> Vivre un jour sans elle me semblait la mort meme.
> To live one day without her seemed to me death itself.
>
> L'homme est un apprenti; la douleur est son maître.
> Man is an apprentice; grief is his master.

To these phenomena, quite peculiar to somnambulisms, were added somewhat different symptoms

which we shall see later on, when we study the tics of respiration; namely, certain moanings or certain monotonous howlings which were regularly repeated for hours together. This is decidedly a type of mixed crisis, in which somnambulisms, exaggerated emotional manifestations, and tics mingle together.

From all these reasons, which show us the identity of the beginning and of the end, the analogy of the essential manifestations, we can conclude that a great number of attacks are nothing but aborted somnambulisms; the idea, which developed itself in somnambulisms through expressions of the physiognomy, words, and acts, now only appears in the inferior and merely emotional form, but these expressions of emotion are enlarged, disfigured. They seem to have become simpler, coarser than in the normal state. The emotions seem to have lost their intellectual aspect and to have increased in their visceral and motor expressions. They appear to have fallen and become inferior.

II

We shall reach an analogous conclusion by examining another equally frequent accident of hysteria; namely, fits of sleep. You know what great curiosity this symptom has always roused. For a long time people had been amazed at seeing individuals remaining quietly asleep, in spite of all efforts to awake them, sleeping on peacefully for hours and even days together.

Such patients, who sleep for ten, fifteen days, some-

times for months together, do not all belong to the same variety. They differ in their physical aspect as well as in their moral state. Some seem to have a rather light sleep; the subject moves from time to time, changes his position, mutters a few words. Others have much deeper sleep, accompanied with complete immobility, or even with a certain degree of stiffness of the limbs. In the last stage this sleep assumes that aspect of lethargy which has given rise to so many superstitious fears. As indicated by the word, the aspect of these patients approaches that of a dead body. The face is of waxen paleness, without any expression, the eyes are closed, and when one opens them, one finds that the pupils are dilated and that the eyes remain motionless; the skin seems to have grown cold, the visceral functions appear to have much decreased, the breathing is superficial and rare, the beats of the heart are hollow and difficult to perceive. It appears that a certain number of patients in this state have been mistaken for corpses and that this accident has given rise to untimely interments. For my part, I am always surprised when I hear of such mistakes. None of the lethargic people I have had the opportunity of seeing could, in my opinion, be the object of any illusion; a little attention was sufficient to avoid this absurd mistake. First of all it is not true, at least in the rather numerous cases I have seen, that the functions stop; one cannot feel the pulse, but, with some attention, one can always hear the heart; if one seeks well, one always finds some manifestations of the breathing. Besides, the temperature is not very low, and the skin

never gives by its contact the impression of a cadaveric skin. There are even some little peculiar phenomena that seldom fail; for instance, that slight tremulousness of the eyelids which is typical, the pupillary reflex either to light or, oftener still, to pain, the change of attitude if the mouth and nose are closed and the breathing hindered. In a word, I do not very well understand how one can mistake a hysteric patient in lethargy for a dead woman, and in my opinion such mistakes imply great ignorance. It is necessary, however, to warn you against this danger.

As I told you at the beginning, I do not think that all hysteric fits of sleep are of the same kind, any more, indeed, than are all attacks. We shall resume this question when we have studied certain disturbances of the visceral functions of hystericals. To-day I wish only to make you understand one of the most frequent forms of these sleeps, the one which, it must be acknowledged, usually seems to be the least profound and serious. It is to be found with those subjects who fall asleep for a few hours and who nearly keep the aspect of normal sleep.

I do not think that in these individuals the psychological phenomena have disappeared; I do not think that their sleep is a merely physical phenomenon. By many methods one can prove the existence of thoughts that continue to develop in their minds. First of all, a protracted and attentive observation very often shows you slight signs connected with thoughts. There are a few little movements of the lips, as if the subject wanted to speak, or sometimes smile, a few little transient ex-

pressions of the physiognomy, a few little movements of the hands. In certain cases, you have quite the impression that the patient chatters inwardly, and that but little is wanting for you to be able to understand him. By means of certain processes which we cannot study in detail, one can sometimes put one's self in relation with such subjects; by merely touching them, speaking to them, it is possible to attract their attention, and then one can question them and obtain certain answers. Sometimes, in the most favourable cases, the subject will answer by speaking; sometimes he will answer by slight signs of the fingers or face. If you take his hand and ask him to press it in order to say "yes," sometimes you obtain nothing but movements of the eyelids and eyebrows: a slight lowering of the eyebrows will mean "yes," their rising will mean "no." And you can thus penetrate a little into his thought. Lastly, in other and more frequent cases, you will be able, after the crisis of sleep, to find again the recollection of it in states of artificially provoked somnambulism, about which I shall tell you a few words at the end of this lesson.

By using these various means, you can ascertain that the immobility of such patients is much less physical than moral. Some have in their mind the fixed idea of sleep or death, and they realize outwardly the attitude they are thinking of. But many others have ideas that are not in the least connected with the sleep. They are seized with a profound revery, in which they contemplate scenes that present themselves before them, or indulge in an endless inward chattering. A girl of six-

teen, who has been terrified by a bull coming to attack her, has crises of sleep, with perfect immobility, during which she is appalled by the hallucination of the bull. Another, aged thirty-two, in despair at the death of a friend, relates to herself dismal stories about her own death: "They are going to put candles near my bed; they are putting me in a little deal coffin; my friends are bringing white flowers to put on my little coffin, which is there, placed on two chairs —" and she talks thus endlessly. A man of twenty-five has been much upset by an accusation brought against him by a fellow-workman. When he meets with this individual, he becomes motionless, like one petrified, and at last he slips to the ground and lies, as if asleep, for hours together, talking inwardly about the accusation brought against him. He fancies he is before his employer, and defends himself in every way, arguing in a complicated manner as if he were before a court of justice.

It is useless to remind you of the fact that we could make concerning these sleeps all the remarks we have made about the beginning and the end of the fits. They are likewise originated by an affecting event, and the same part is played by the provocative circumstances, which, by an association of ideas, recall the initial event. You have just seen an example in which sleep is provoked by the sight of the person who brought the accusation. We could resume the same discussion about certain special points which have been called *hypnogenic points*. In my opinion, these points do not act at all for physical, but for moral reasons, because the sensations they bring about are associated with the affecting idea. At the

end of these fits of sleep, there occurs the same awakening with indifference, and especially the same oblivion, exactly as in somnambulisms.

You see, therefore, that these new phenomena do not differ very much from the preceding ones. However, you remember that, in somnambulisms, there were intelligible words, complex acts, and expressive movements; in attacks, the words and acts had disappeared; in the fits of sleep, which we are now considering, there remain not even movements or convulsions. It seems, therefore, that all the phenomena of somnambulism have disappeared.

But these missing phenomena are not, in my opinion, essential phenomena. What was most important in somnambulism was, as I told you, an idea persisting in consciousness and developing to an exaggerated degree. The development is complete if it manifests itself by emotional expressions, by words and acts; it is much less complete if nothing remains but the first term; namely, the emotional agitation; yet the idea may still persist and pervade immeasurably the consciousness of the patient, without manifesting itself by anything outwardly. The subject is then invaded by a kind of meditation from which nothing can distract him; he perceives no phenomenon foreign to his dream, and this is the reason why he cannot be awakened by any means whatever, and takes on the appearance of being in a profound sleep. So we were right in saying that this form of hysteric accident was also connected with somnambulism, of which it was only the last degree.

III

I should not like to conclude this study of hysteric somnambulisms without indicating to you in its proper place, if not a new form, at least an important characteristic of all the preceding forms. A very curious property of hysteric accidents, which, no doubt, is not absolutely peculiar to them, but which, carried to this degree, is rare, is that they can be artificially reproduced.

In most diseases, the accidents are not at our disposal. To take only one striking example, we are not at all masters of an epileptic fit; we cannot stop it at will, nor can we reproduce it, or make it reappear when we please. Let us take, for example, an individual who has been affected with epilepsy for ten or twenty years, and who very frequently has the most decided epileptic fits. Well, if we wished, for any reason, in the interest of the patient himself, to study his epileptic fit, if we wished that a fit might take place in our presence in the laboratory, where we have the time and the means to examine its details accurately, we could not, as you know, realize this wish. We can take the patient before us, try him in every way, but he will present no pathologic phenomenon. He will not be impressionable at all, he will not have the shadow of an epileptic fit. An hour afterwards, when we are gone, and without our knowing why, he will suddenly fall and have a great epileptic fit. It is a disease on which experimentation has no hold. Formerly it was so with three-fourths of the

diseases; nowadays, owing to the discoveries of physiology, of microbiology, and sometimes of psychology, we begin to be able to reproduce in the laboratory some of the diseases we want to study. You know that it was a revolution when Pasteur demonstrated that the cattle plague, — the carbuncle, — could be given to an animal when one pleased. It is the beginning of medical science, and sometimes of therapeutics, to be able thus to bring about the outbreak of a disease at will.

Well, this character is developed to the highest degree in hysteric neuroses, and it applies especially to the somnambulisms of which I have just spoken. Notice first that it is a constant symptom of monoideic somnambulisms. We have only to awaken in a more or less precise manner in the mind of the subject the idea whose development fills up the somnambulism, to cause the latter to reappear. Sometimes, to awaken such an idea, it is necessary to recall it completely, to describe it, to dwell on the images that constitute it; sometimes it is sufficient to make a sign, to call up a term associated with that idea, for the rest of the somnambulism to develop, owing to the automatic association which you know. Speak of Pauline to that young woman who wanted to imitate her by throwing herself out of the window; she will think of the suicide of her niece, go towards the window and begin all the scene over again. Question Irene on the death of her mother; you will see one of the following different phenomena: either, as we have noted, she understands the question, only partially answers us vaguely, has no accurate remembrances relating to her mother's death, nor even

to her illness; or, if you insist a great deal, if you remind her of facts characteristic of the agony, the subject will lose her composure, be agitated, and cease to hear us or see surrounding objects. She will soon be absorbed in her dream, and then will recite in a declamatory tone the details of the agony we spoke of, and begin to play the scene of the death and of her own attempt at suicide under an engine; the somnambulism has begun again.

What we have just said applies to all the other forms of somnambulism; to polyideic somnambulism, in which the dream, when once begun, is transformed by the appearance of new circumstances; to fugues themselves, which we can make the patients recommence by dwelling on the dominant idea. Many of the fugues of young R. were in some manner experimental; his comrades provoked them by recalling through their chatter the stories of travels which had impressed the patient. Nay, more, — the fact is but little known, — double existences can be experimentally reproduced. Allow me to recall this remarkable observation on which I have often insisted already, that of Marceline, whom we have just studied in our preceding lecture. This patient, as you know, was transformed by hypnotism and kept during fifteen years two existences, the former with depression, anesthesias, amnesias, anorexy, etc., brought about by the hysteria; and the latter with rather good health, normal sensations, and memory determined by artificial excitation. She had really become a kind of artificial Felida, and she shows us that double existence itself can be reproduced by artificial means.

What I have just told you of somnambulisms is still truer with respect to those incomplete forms of somnambulism which we have just studied under the name of emotional fits and fits of sleep with revery. Those who described the hysterogenic and hypnogenic points had insisted on the following character; namely, that at any moment you could, by the excitation of these points, cause the patient to fall back into the attack or sleep. One fell into convulsions as soon as her lower abdomen was pressed, the other into a fit of sleep when one of her breasts was touched. We know now what these phenomena mean; they belong to the same group with the preceding ones. The sensation provoked is again a signal associated with the group of psychological phenomena of the crisis. I shall only recall the essential fact; namely, that we can make these phenomena reappear artificially.

The states thus artificially reproduced, the somnambulisms especially, are not long in being a little modified. After a certain time, they are no longer quite identical with the original, natural phenomena. The reason of this is, as we saw when we studied polyideic somnambulisms, that new ideas may develop in this state without stopping it. An idea that plays a great part is the idea of the experimenter who has artificially provoked the state. The latter is more and more capable of introducing himself into the somnambulism of the subject. At first he can only be understood by the subject if he speaks to her of ideas related to the somnambulic dream, but he is soon himself a part of the dream and is heard and understood if he speaks of any-

thing whatever. The greater and greater influence the experimenter acquires over his subject is not long in transforming the somnambulism, in giving it a form and laws that are often strange and simply result from the habits of the experimenter. One teaches his subject always to to say "thee, thou," during the somnambulic state, whereas she says "you" in the normal state; another accustoms her to fall profoundly asleep when her eyes are touched, and to wake up when her vertex is touched. Such phenomena were formerly presented as laws of somnambulism, and gave rise, at the time of Charcot, to many passionate discussions. Thus is formed in some subjects an artificial somnambulism, which has been given the name of hypnotism.

This hypnotism raises one last serious question, which we cannot treat in detail, and on which I confine myself to giving you my personal opinion. Is this hypnotism something distinct from hysteric somnambulism? Is it something peculiar, an abnormal state independent of hysteria? You remember what great battles have been fought on that point. For my part, I do not hesitate, and these are the principal reasons for my opinion: first, considered in itself, the hypnotic state has never any character which cannot be found in natural hysteric somnambulisms. The modifications it offers are very easily explained as the result of education.

Secondly, if you examine the subjects with whom this state can be obtained, you will be convinced that they are mostly hysteric patients, having already had somnambulism in some form or other, or for the remaining

part hysteric patients having presented other accidents, but having the mental state characteristic of hysteria.

Thirdly, you can verify, if you examine matters without preconceived ideas, the fact that subjects troubled with other diseases than hysteria — epileptics, for instance, psychasthenics tormented by the mania of doubt, lunatics affected with systematic delirium — are not at all hypnotizable, and that one will never be able to reproduce in them a real somnambulic state with complete consecutive amnesia.

Fourthly, and I find this remark very important; this artificial somnambulism is healed and disappears in the same manner as natural somnambulisms. A subject whose hysteria decreases, who tends towards recovery, whose mental state changes, ceases to be hypnotizable.

Fifthly, and lastly, these two states are so analogous to each other that you can pass from the one to the other by imperceptible transitions. You can enter into relation with an individual in natural somnambulism, first speak to him of his dream, get him to listen to you, then direct his thoughts and afterwards put him into the hypnotic state at will. Inversely, the hypnotic state, if you do not sufficiently direct the mind of the subject, can be transformed into a state of independent dream, into a state of hysterical somnambulism.

In a word, it seems there is no reason for making a special place for the hypnotic state; it is a somnambulism analogous to the preceding one, and differs from it only in that it is obtained artificially instead of devel-

oping spontaneously. So we have passed in review the different forms of somnambulic accidents that characterize hysteria and constitute more than half of the accidents of this neurosis.

LECTURE VI

MOTOR AGITATIONS — CONTRACTURES

Disturbances in the motor functions of the limbs — Apparent exaggeration of motion — The phenomenon of tics — Rhythmical choreas — The absence of will, of consciousness, anesthesia — The diagnosis — The tremors — The contractures — Clinical importance of this accident — The part played by mental phenomena — The degradation of the movements in these hysterical accidents

Hysteric neuroses, the history of which we are pursuing, very often present accidents of quite another nature, which at first sight seem to be different from somnambulisms. These accidents do not affect the whole of the body and of the mind, like the former; they seem only to disturb certain functions, and, in particular, the accidents we consider to-day appear only to disturb the motor functions of the limbs. In spite of the disturbances seated in the arm or leg, the mind may appear, at least in certain cases, absolutely intact, while in somnambulisms the delirium seemed to be general. In the second place, motor disturbances, which we now consider, are not momentary, but they are lasting. Instead of appearing, like attacks and somnambulisms, at determinate moments, and disappearing in the interval, they may last for a long time, for days and months together, no matter what the state of the subject may be. They may exist during the fits

and also exist in the interval. So you see that the phenomena are apparently pretty different.

Yet most physicians, especially since the end of the last century, do not hesitate to connect this ensemble of motor disturbances with the same neurosis, with hysteria. Perhaps we shall be able to justify this diagnosis later on by showing that the mental disturbance is at bottom about the same as in somnambulisms. For the present, we cannot ground our argumentation on this still unknown character, and we are obliged to justify the diagnosis of these disturbances of motion by mere clinical remarks. We observe only that they present themselves in the same subjects and in the same conditions as the preceding somnambulisms. The patients we shall describe to you to-day who have had these perversions of motion, these agitations or paralyses, are the same whom we already know; they had, a short time before, monoideic somnambulisms, fugues, or fits. They can still, if we choose, enter into those hypnotic states which we consider as the reproduction of spontaneous somnambulisms. In them, these various accidents alternate with one another. After a fit they may have spasms or paralysis; inversely, these disturbances of motion may disappear in a new fit or a new somnambulism. No doubt, these are not absolutely irrefutable reasons, and it will be necessary to complete the diagnosis when we know better the nature of these motor phenomena; but after all, these reasons are sufficient to induce us, while pursuing the study of the hysteric, to enter into the examination of these phenomena which these patients often present.

The motor disturbances that have the preceding characteristic are very various and irregular; we could range them in two large groups: first, phenomena of at least apparent exaggeration of motion, which seem to exceed the will of the patient and to develop inopportunely and without his consent, and second, phenomena of deficiency, in which, on the contrary, motion seems to fail and not to obey the will and consciousness of the subject. In the first group, which we designate under the general name of *motor agitations*, are to be ranged *tics*, *choreas*, and *contractures;* in the second, the strange *functional paralyses*, or paralyses dependent on ideas; to-day we shall study only the first group.

I

You all know the commonplace phenomenon of *tics*, which is to be met under so many circumstances; I advise you to keep the French word because I do not find in the English language a good translation. You must not fancy that all tics are hysteric. There are some epileptic tics, and even oftener, psychasthenic tics, but, to confine ourselves to our preceding diagnosis, there are some tics that are to be met with in patients who have already had all the preceding forms of somnambulism, and that alternate with these somnambulisms.

These tics are essentially constituted by little movements of the face, head or limbs, which appear at random, without any relation either to the present circumstances or the consciousness of the patients. This

name is generally reserved for rather sudden little movements of short duration, and other terms are used when the same involuntary movements have a greater extent. These little muscular shakes may present themselves in all parts of the body. You may especially notice them in the face; they constitute grimaces of a thousand kinds, affecting the eyes, the nose, the mouth. The patient puckers his forehead in various ways, raises or lowers his eyebrows, winks, looks sideways by starts; he makes his nostrils tremble, closes or opens them too much. A very interesting patient, whom we shall study with more detail to-day, blows violently through his left nostril. Others seem to wipe their noses or to sneeze; their lips suddenly draw to the one side or the other, stretch forward or shrink backward, or else are continually bitten — the upper lip as well as the lower one. The tics of the neck have been brought into notice by being described under the name of psychic stiff neck; involuntarily and suddenly the patient inclines his head towards one shoulder, or throws it back, or bends it forward, or turns it on its axis. He repeats these movements every two or three seconds in a way which it is impossible to explain or justify by any present reason.

I do not speak now of the tics related to the visceral functions such as the alimentation or breathing tics; I at once pass on to the tics of the limbs. In these the arms, the hands, seem to have taken strange habits; they rise suddenly or move backwards; the shoulders are shaken convulsively; the legs, instead of regularly performing the act of walking, every moment interrupt

it by a strange little shake of the knee or foot or toes. These little movements, which have innumerable forms, of course impede every action of the arms, and when they occur in the waking state, they often make walking almost impossible.

Let us proceed at once, in order not to interrupt the description, to the same kind of involuntary and useless movements that have a greater extent and, for that reason, have been called *choreas*. This distinction is not essential at the bottom, and must not prevent us from putting all the motor agitations in the same group. The first choreas that physicians decidedly connected with hysteria were the *rhythmical choreas*, thus called because the movements were repeated regularly at determinate intervals, like those of a pendulum. This kind of rhythmical movements occurs very often in the hysteric fit; it constitutes those complications of the simple fit which I have pointed out to you. Very often the patients, without recovering consciousness, cease their emotional manifestations to indulge in some odd and perfectly regular gymnastics.

One of the most commonplace is the salute, which Charcot described; the patient, lying on her bed, sits up, bends her head and body forward, sometimes low enough to touch her knees, as if she were making a salute, then suddenly throws herself back till her head falls on her bed. After a moment, she begins again; she may thus make this salute twenty or forty times a minute for hours together. Others have malleatory movements of the arm or leg; you would think they

strike regularly with a hammer. Others again have saltatory movements; either when lying or when standing, they appear to jump or dance regularly. Besides these definite classified movements, there are hundreds of others which have no definite name; this one clinches her fists and suddenly brings them together towards the middle of her body, then separates them, and begins again indefinitely; another turns her right wrist as if it were fixed to a wheel, and so forth indefinitely. In all such acts there is always the same rhythmical regularity; Charcot quoted, in reference to this, the sentence in Hamlet: "Though this be madness, yet there's method in it," and wished a ballet-master might observe and write down the strange and regular movements of the patients.

These movements have their maximum of strength and rhythmical regularity during the fit; but it is characteristic of the motor agitations we speak of, that they may very well persist in the interval of the fits. The patient speaks correctly; he is in possession of the whole of his consciousness, has all his recollections, can even execute movements with his unharmed limbs, but he continues to make the rotary movement with his right hand and bring his two hands into contact or separate them.

Though the more distinct hysteric chorea is thus characterized by a rhythm, you must not fancy that every other chorea in which there is no rhythm is necessarily outside the great neurosis; that was believed formerly, but this too simple diagnosis had to be reformed. No doubt, a very irregular chorea, consist-

ing in characterless shakes of the arms and legs occurring without any kind of regularity amidst voluntary movements, is usually the common chorea, called chorea of Sydenham, with which we have not to deal. If, however, such a chorea appears in adults or young people after their puberty, you must be on your guard, for such choreas, though arrhythmic, may very well depend on hysteria. A young woman thirty-one years old, terrified by an explosion in a factory where she worked, presented for more than ten years, deliriums, fits, somnambulisms of all kinds which were unquestionably hysteric. Amidst these various accidents, taking their place or alternating with them, she had very long periods of chorea. This chorea of all the limbs and of the head presented no kind of rhythm, and yet we do not hesitate to maintain that it was a hysteric phenomenon like the other accidents of the patient. We have noted about twenty quite typical observations of this kind, which clearly show that the arrhythmic chorea must be counted among the possible forms of hysteric motor agitation. Its diagnosis then depends not only on the previous and simultaneous accidents, but also on the mental state which accompanies it, and on which we must now insist.

II

Whatever may be the tics or choreic movements that these patients present, you observe a certain number of psychological characteristics accompanying them, which characteristics are the easier to discern as these

motor accidents continue during the waking state and it is possible to question the subject about what he feels. When the movement thus exists during the waking state, one can better realize the mental state that accompanies it.

First of all the will of the subject has no influence on it. Of course, the subject asserts that he does not want at all to make this movement, and by all his conduct shows us that he would very much like to be rid of it, but he cannot stop it any more than he can produce it. The efforts of his will appear powerless; by making great efforts he can at most disturb the rhythmical movement, make it less regular, complicate it with shakes of the rest of his body. The movement is not stopped, and begins again more regularly when the subject gives up his efforts of will.

Consciousness does not seem to have a great hold on this phenomenon either; the subject seems to be scarcely aware of his tic or his chorea; very often he performs it without knowing it; even when he is attentive, he feels it but little or even not at all; when he shuts his eyes, he may very well declare that now his arm no longer moves at all, while the movement continues with perfect regularity.

We see those phenomena of insensibility appear here, which will play a greater and greater part in hysteric accidents. When treating of somnambulism, we spoke but little of insensibility; in the first place, when the somnambulism is at an end, this disturbance may fail entirely; a somnambulist is not necessarily insensible in the waking state; he is merely amnesic; it is amnesia

that is the stigma of somnambulism, and not anesthesia. Then during the somnambulism itself, there is, it is true, a certain anesthesia, but it is very peculiar, and only affects the phenomena which are not connected with the subject's dreams. When we come to motor disturbances, that insensibility which is called hysteric anesthesia begins to intervene. It may present itself in two ways; sometimes it is systematic and bears only on the movement that constitutes the tic or the chorea. The subject does not feel that he moves his forehead, or that he strikes his bed regularly with his hand, but he feels the other things, and in particular, is able to tell you that somebody seizes his hand while he is performing the choreic movement. Notice this systematic anesthesia, which will become more and more important. Sometimes the anesthesia is more important, and the whole of the limbs affected with a tic or a chorea is insensible. For instance, one of the subjects to whom I alluded used to turn his right hand in a circle and had a see saw movement in his right foot; the whole of his right side was nearly insensible.

These anesthesias, this kind of unconsciousness, must play a certain part in the diagnosis; you will not meet again with the same characteristics in the same degree in tics of another nature, particularly in the tics of the psychasthenic. With the latter, the tic, while appearing involuntary, is accompanied by a great deal of consciousness and attention. The subject performs his tic when he thinks of it, when he directs his attention to the organ and tries to keep it motionless. It seems that, with these patients, attention increases the

tic instead of diminishing it. Inversely, you may observe that distraction sometimes has a good effect. When the subject forgets his disease and his mind is absorbed by something else, he leaves off performing his tic. You see that with him the tic is conscious, that it is in connection with thoughts the subject possesses. There is, therefore, no anesthesia in this case. The subject feels his movement very well and all that passes in the diseased limb. With the hysteric, the movement is impeded by attention; it develops, becomes more complete and regular in a state of distraction; it is much oftener accompanied with anesthesia.

These characteristics, which serve to make the diagnosis, also enable us better to understand the nature of the phenomenon. In fact, the tic and the choreic movement are much more intellectual phenomena than they appear to be. We notice many mental phenomena at their beginning exactly as at the beginning of somnambulisms. One has had an accident to his face or eye, another a pain in his teeth; the man who constantly blew through one of his nostrils had had for a long time a scab in his nose, consequent upon a bleeding at the nose. All the patients who have had mental stiff necks had had some moral impression relating to a movement of the head. A girl I am attending now felt very dull at home; she worked all day long by a window that looked out into the street. Her strongest desire was to leave her monotonous work and go out into the street at which she constantly looked. At every moment she lifted her eyes from her work and turned her head to the left in order to see what was going on in the

street. She gradually felt that her head constantly turned to the left, and even maintained that her hat was too heavy on that side. An absurd diagnosis, the application of a plaster bandage, had singularly aggravated her state, and now she has a bad mental stiff neck on her right side.

These ideas, these more or less definite mental phenomena which existed at the beginning, persist throughout the development of the tic or the chorea. Let us return to a singular story, which I have often related. It tells how the rhythmic chorea of that girl of sixteen had begun, who kept on turning her right wrist and regularly raising and lowering her right foot. One evening, on the eve of the quarter-day, she had heard her parents, who were poor work-people, bewailing their poverty and the difficulty they had in paying their landlord. She was very much moved, and from that time she had at night a kind of somnambulism, during which she tumbled and tossed in her bed and repeated aloud: "I must work, I must work." Now, what was the work of this girl? She had a singular trade, which was to make dolls' eyes, and, for this purpose, she worked a lathe by treading a pedal with her foot and turning a fly-wheel with her right hand. During her nocturnal somnambulism, she made this movement of the hand and of the foot, but this movement was evidently accompanied with a corresponding state of consciousness, since she repeated aloud: "I must work." It was a simple somnambulic action, like all those we have studied. On awaking, she no longer has any recollection or consciousness of her dream, but the

movement continues exactly the same on her right side. Is it not likely that it is still accompanied with a state of consciousness of the same kind?

We can make this state of consciousness evident by certain experiments which we know now how to effect. By hypnotizing the subjects, you find again dreams that account very well for the continuation of the tic. For instance, a young woman comes to complain of a pretended vertigo; it appears that, in the street, every hundred steps, she feels herself as it were precipitated forward, that she suddenly takes a leap and has often fallen while taking it. What a strange vertigo! In a state of induced somnambulism she relates to us what follows: Once she went to her parents, who sharply reproached her for her irregular conduct. On going out of their house, she took a resolution that simplifies many things, — she made up her mind to commit suicide, and in a dream, of course, for she was, happily for her, hysteric to a high degree — she fancied she had got upon the parapet on the bank of the Seine, took a leap, and was awakened by a fall to the ground. In all such cases, the existence of a system of images that works unknown to the subject is undeniable.

The difficulty is greater in the case of great uncoordinated choreas, in which all the motor functions seem to take a part. It is no longer merely a special thought, a system of images that seems to develop outside of consciousness, it is a function in its entirety, the function of moving the arm or leg, that seems to emancipate itself. Let us notice for the present this phenomenon, which appears to us for the first time; it will become clearer and clearer through new studies.

III

Indeed, the problem raised by such dissociated motor activities working separately, outside of consciousness, becomes singularly complicated when we examine other forms they may assume, which are among the most important phenomena of hysteria. I refer to *tremors* and *contractures*.

In a very great number of cases, hystericals have other disturbances of motility than tics and choreas. Their limbs are affected with a strange agitation differing from the preceding ones; for example, they are seized with tremors; the arm has regular little oscillations, of an average rate of five to nine a second. These oscillations are nearly continual. There are some subjects with whom they never stop, either when they rest or when they move; there are some others with whom these tremors are intermittent, disappearing at the time of voluntary activity and increasing at the time of diversion and rest. But it is not possible to establish any rule, for you often observe the reverse in the form of intentional trembling, analogous to that of disseminated sclerosis; the subject, almost motionless when at rest, begins to tremble when he seeks to perform a movement (Figure 7).

These tremors occur under various conditions, sometimes gradually, after paralytic phenomena, very often suddenly, after an emotion. One of the finest cases I have observed is that of a workman, who, in consequence of the breaking of a scaffolding, remained

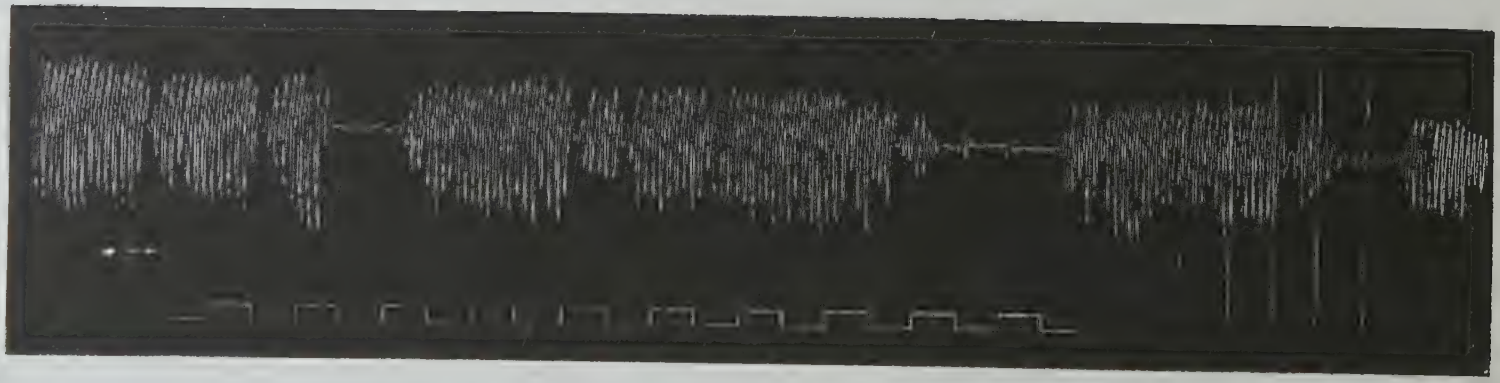


FIG. 7. — Graphic of a case of hysterical tremor. The arrow indicates the direction in which the graphic must be read. The inferior line gives the time in seconds.

suspended at the height of a sixth floor. Others began to tremble after a fright, after receiving bad news. In one of my observations, the tremor which began in the right arm was consequent on a dream. The subject fancied he was pushing back an assassin with his right arm.

In some rare cases, you can find behind the tremors, as behind the tics, the existence of a fixed idea separated from consciousness. A woman who presented an intense tremor of the right hand at last confessed that this tremor had appeared in consequence of her having long practised automatic writing in order to question spirits. It was enough to put a pencil in her right hand for the tremor to cease and to be transformed into writing.[1] So we had certainly to deal with a kind of tic, with an incomplete subconscious action which assumed the appearance of a tremor.

But, in most cases, there is nothing behind the tremor but a vague emotive state and a kind of transformation of the motor function of the limb.

It is what we observe in a higher degree in the exceedingly serious phenomenon of hysteric contractures. You know that the history of this phenomenon may be said to begin with the lessons of Brodie, 1837, "Lectures Illustrative of Certain Local Nervous Affections"; then we have the works of Coulson, 1851, of Paget, 1877, of Charcot, of Lasegue, of Paul Richer. This history corresponds to the evolution of the greatest problems of medicine, for physicians have been led gradually to separate the hysteric

[1] See "Nevroses et Idees fixes," II, Observation 95, p. 332.

contractures from all the osseous, articular, medullary, and nervous affections with which they were formerly confounded. It amounts to saying that this problem is connected with everything in medicine.

This contracture is a state of moderate contraction of an ensemble of muscles which maintains a limb in a determinate position, and that in an involuntary, unconscious, and indefinite manner. Such contractures can be observed on absolutely all the muscles of the body, and in each region; they raise medical problems which I can only point out to you. In the eyes, they determine the spasm of the orbicularis and the occlusion of the eyelids; at the mouth, they are located very often on only one side, and they bring on the distortion of the face. In both cases, they must be carefully distinguished from paralytic phenomena, which they simulate; from the ptosis of the eyelids, which fall passively instead of contracting; and from the paralysis of one side of the face, which equally causes the face to deviate to the opposite side. You know the importance of the ptosis of the eyelids and of the unilateral paralysis of the face; the diagnosis is of capital importance. The contracture may be seated in the neck, back, abdomen, or thorax, and in each place new problems arise. Here it simulates diseases of the vertebræ, deviations of the vertebral column; here it transforms the breathing and causes you to believe there is a pulmonary disease. In other cases it assumes the appearance of all possible tumours of the abdomen. It is these contractures which originate the great medical errors of which hysteria is the occasion. As regards the limbs, we have the con-

tractures of the legs, of the hip, with the important problem of the white tumour of the knee and of tuberculous coxalgy. I think the most expert physician ought never to boast that he will make no mistake when he has to decide between hysteric coxalgy and tuberculous coxalgy. As regards the arms, the difficulty is not so serious in general; yet you must beware of false luxations of the shoulder, of arthrites, and of cysts of the elbow or wrist. There is not a more important clinical problem than that of contractures.

Curiously enough, we also meet here with an important psychological problem, with a question that is certainly one of the most obscure of pathological psychology. It is obvious that a certain number of the phenomena connected with these contractures are very clear; first we know that contractures are consequent, like all hysteric phenomena, on thoughts and emotional phenomena. A shock has no action in this direction except when it determines great phenomena of imagination. I will explain myself: An individual has his legs in a state of contracture because, he says, a carriage ran over them. After verification, it is found that the carriage passed beside him, and that he felt nothing at all. A real shock would do less than this imaginary shock.

According to all the observations that have been made, the production of a contracture requires, exactly as does that of a somnambulism, some emotion, some fear for the future, some terror, some dream, etc. It is the same with the cure of these contractures; in certain cases they persist indefinitely. I have two cases

which lasted for thirty years. In other cases, they are suddenly cured through influences that are incomprehensible if one does not take into account imagination and emotion. These diseases are among those which make the fortune of religious relics and miraculous springs. When you hear a story about a cripple with hard shrivelled legs, twisted under his body, who was rolled to the spring in a low carriage, and got up again, bearing away his carriage on his shoulders, you need not have the least hesitation in pronouncing the case one of hysteric contractures. If you are fond of erudition, I recommend you to read the admirable book of Carre de Montgeron on the miracles wrought in the cemetery of Saint Medard on the tomb of Deacon Paris, 1737.

It is also phenomena of this kind that physicians have cured in determinate conditions by all sorts of processes, by the electric current, by magnets, by the application of metallic plates, by merely speaking to the patients. So there are a great many psychological phenomena as well at the end as at the beginning of contractures.

You also meet with some during the time the phenomenon itself lasts. First of all, the contracture is more frequently systematic, at least at its beginning, than is generally believed. The limb is not stiff in every position; depending on the unequal strength of the different muscles, it keeps a particular attitude requiring a certain harmony of permanent contractions. A woman has seen in the hospital an individual who had died of tetanus; she reproduces his attitude, and keeps her head thrown back. Another, of whom I have

often spoken, constantly keeps both her feet extended in the position of Christ on the Cross; she has, moreover, a religious delirium in which she thinks herself crucified. She has crises of somnambulism and catalepsy in which her trunk, arms, and head remain, for hours together, absolutely in the attitude they must have in a crucified person.[1] During these crises the entire attitude decidedly corresponds to a delirium and to thoughts. When, in the interval of the crises, the feet alone keep the contracture, it is very likely that something of the delirium persists.

From another point of view we may notice that the contracture varies with certain psychological facts. If the subject is very quiet, if nobody touches her contractured limb, and if she herself does not try to make a voluntary movement, we may see that the contracture decreases and that the limb unbends. Lastly we may observe in contractures many forms of insensibility; the subject does not feel the fatigue of this permanent contracture, very often she does not feel anything at all in her contractured limb. In a word, you see that we may notice in contractures a great number of facts analogous to those we have observed in tics and choreas, showing us a kind of abnormal functioning of a psychological system which in some way or other has become independent.

I must however add that we meet here with a new difficulty, the germ of which, indeed, was already to be found in choreas and tremors. Let us try, with our

[1] "Une extatique," *Bulletin de l'Institut psychologique international*, 1901, p. 209.

sound limbs, to copy the attitude of a rhythmic chorea and register our movements accurately. You will find that you are much more awkward than a hysteric person, and that, unless you have practised specially to this end, you cannot obtain the same regularity. Try to keep your arm in the position of a hysteric contracture and describe the movement of the arm; you will remark that you have not the same perseverance or courage as the patient. After a short time, your arm trembles and is displaced, while the hysteric contracture has not changed. If therefore we suppose there is a psychic action in these hysteric phenomena, it must be acknowledged that this action is not identical with ours, but that it is performed in other conditions.

Here is my hypothesis; think of it what you please; the actions that are manifested by muscular movements present different degrees of perfection corresponding to the development and systematization of the consciousness that accompanies them. These degrees of perfection are manifested first of all by psychological characteristics of the action, delicacy, harmony, usefulness of the act, but it is also manifested by properties of the movements themselves. The muscular movement of a draughtsman's hand is not the same as the muscular movement of a dog's or a crocodile's paw. There are some particular physiological properties accompanying the perfection of the act. Some are known: the rapidity of the contraction is much greater, and in particular the rapidity of the decontraction, of the fall of the muscle, is much more considerable. In the muscles of the lower animals, the contraction takes

place slowly and disappears slowly. We see also the same modifications of the muscular contraction brought about by fatigue. By repetition, muscular contraction changes, becomes slower, has a long period of decontraction as in the case of lower animals. I even think — excuse the temerity of these suppositions — that there must be in these different muscles and in these different states of activity of the muscle some anatomical differences. Great stress has been laid recently on the two organs that exist in the muscular fibre: the fibrils which give short contractions, and the sarcoplasm which gives long and permanent contractions. The latter predominates in the smooth fibres of the viscera, the former in the striated muscles of the voluntary movements. I suppose that it will be possible later on to observe some modifications in the proportion of these two substances in the muscles of different animals according to their state of evolution, and in the different states of the same muscles in rest or in fatigue, for instance.

Now action, by becoming unconscious in hysterics, by separating from consciousness, loses something of its dignity, retrogrades in a manner and assumes an appearance that recalls the action of the visceral muscles, the action of the lower animals, and the movements of the fatigued muscles, as if the activity of the sarcoplasm prevailed over that of the fibrils. This is what, in my opinion, gives to the subconscious actions of the hysteric those abnormal characteristics we saw in tremors and contractures. It is this general idea that prepares us for the examination of the phenomenon of hysteric paralyses.

LECTURE VII

PARALYSES — DIAGNOSIS

The clinical study of hysteric paralyses — The beginning of these paralyses — Traumatic neuroses — The most frequent types of paralysis — The diagnosis of hysterical paralyses — The intrinsic characters — The localization and form of the paralysis — The examination of the reflexes — The value of the different signs — The extrinsic characters — The modification of sensibility — The description of hysteric anesthesia

FASHIONS prevail in medical studies as in costumes. At one time, one problem raises general enthusiasm, and everybody gives it his exclusive attention, forgetting all the others. Twenty years ago, it was hysteric somnambulism that was in fashion; nowadays, one seems very much behind the age when one speaks of somnambulism. The latest fashion is to apply one's self only to the study of hysteric paralysis. Let us follow the fashion and reflect for a time on this curious problem of physiology and psychology. This lecture will be devoted to the study of hysterical paralysis from the clinical point of view. The next lecture will analyze the psychological features of paralysis and anesthesias.

The hysteric are capable of completely paralyzing a part of their body. You know what I mean by such an expression. I need only state that patients who have had the accidents we spoke of before, fits of all

kinds, simple or complicated somnambulism, choreas of a special kind, mysterious contractures like those we have seen, may besides have paralytic accidents. It does not mean that a paralysis that presents itself in a woman who has had fits and somnambulism is necessarily a hysteric paralysis, obeying the psychological laws of this kind of disease. It even seems to be the clearest result of the present studies, which have spread everywhere nowadays, to show us that it is not always so; that often, very often even, the paralysis that appears is a commonplace paralysis, corresponding to a cerebral or medullary lesion. The diagnosis to be made is exceedingly difficult and important, but it is nevertheless true that, in a certain number of cases, these subjects have paralyses analogous to their other accidents, whose evolution is the same and whose diagnosis and nature we must study.

I

These paralyses appear in about the same circumstances as the other phenomena; they are always brought about by an accident which, while very slight in itself, is accompanied by a violent moral emotion and by disturbances of the imagination. One of the oldest cases, and a very interesting one from a historical point of view, is quite typical. I allude to the observation of Estelle, which originated the remarkable book of an old magnetizer, M. Despine d'Aix,[1] in 1840: A girl

[1] Dr. Despine pere (d'Aix). *De l'emploi du magnetisme animal dans le traitement des maladies nerveuses, suivi d'une observation tres curieuse de guerison de nevropathie.* 1860.

twelve years old had fallen into a passion, and, against her mother's will, had quarrelled and fought with one of her little friends. In the heat of the fight, she had been knocked to the ground, and had fallen rather violently on her posterior. This fall had been complicated by an aggravating circumstance; namely, her frock had been much dirtied in a particularly significant part. The pain was slight and did not prevent the girl from getting up again and returning home; but what is essential is that she experienced a feeling of shame, of fright, and tried to hide her fault. The next day began a complete paralysis of both legs, a serious paraplegy which lasted eight years. Bear this in mind — eight years' paralysis of the lower limbs for having fallen lightly on her backside.

Such facts were hardly known at that time to any but to those strange magnetizers. The same authors of whom we spoke lately, Brodie, Todd, Duchenne (de Boulogne), Russell Reynolds, Charcot, Oppenheim, and all the modern authors, were the ones who began to study what was first called *traumatic neuroses*. Indeed, traumatic accidents are among the most frequent causes. Railway catastrophes give rise to many of these accidents, and some physicians had even adopted the expression of *railway spine*. Falls from carriages, from horseback, and shocks received in battles are their most common origin.

For instance, a drunken carter falls from his box on his right arm and presents a paralysis of this arm. A man of eighteen falls in a staircase on his back; the consequence is a paralysis of the legs and a contracture of

the lumbar muscles. Often the shock is only imaginary; the celebrated patient who appears in the first lessons of Charcot thinks he has been wounded by a carriage which did not run over him. One of the last observations I have noted is very strange: A man travelling by rail had done an imprudent thing: while the train was running, he had got down on the step in order to pass from one door to the other, when he became aware that the train was about to enter a tunnel. It occurred to him that his left side, which projected, was going to be knocked slantwise and crushed against the arch of the tunnel. This thought caused him to swoon away, but, happily for him, he did not fall on the track, but was taken back inside the carriage, and his left side was not even grazed. In spite of this, he had a left hemiplegy.

Other circumstances may act similarly, as, for instance, fatigues, especially when located in a limb. A house-painter felt his hand very tired while painting a ceiling, and presented a severe paralysis of his right hand. I found it likewise in a girl who was learning the violin, in those who had tired their hands on the piano. But here again, to the fatigue must be added an emotional state, as in this classical observation of Fere; a girl who tires herself in learning a piece on the piano is seized with a paralysis of her right hand at the moment when she is to play this piece at a ceremony. The part of emotion is so great that it may be sufficient, when added to a purely imaginary fatigue, as in this other observation of Fere: a girl dreams at night that she is pursued by a man and that she runs very fast in

the streets of Paris; she dreams that she is exhausted with fatigue, though she has not moved. The next day she is none the less paraplegic. Lastly, there are some paralyses that follow somnambulisms and crises, without our knowing very well for what reason, but as we shall see later on, they affect limbs formerly paralyzed, or having in them causes of decay, rachitic deformation, old scars, varices, etc.

The paralyses thus brought about may be very various. For the present, I only point out to you those most common and most anciently studied; I reserve others for the end of this study, because they are particularly interesting as regards the interpretation. The most common hysteric paralyses seem to be analogous to the great organic paralyses. The most frequent, the most carefully studied, nowadays, is great *hemiplegy*, in which one half of the body is completely paralyzed. Usually, it is true, hysteric paralysis strikes the limbs rather than the face, but the rule is not absolute; when the paralysis is in the right side, for instance, the face and speech may be paralyzed as well as the arm and leg. Here is a girl of nineteen, already neuropathic, and daughter of an epileptic mother, who lost her father a fortnight ago. The poor girl supported him with her right arm during his agony; on the very evening of the day on which he died, she felt exhausted with fatigue, especially in her right side, and her right leg trembled when she tried to support herself on it. She could not sleep, thinking every moment she saw and heard her father. The next morning, she had a pain in her abdomen, the menstrual discharge reappeared out of

its period, the weakness in the right side had increased. On the third day the right arm and leg could still move, but trembled continually. On the following day the right hemiplegy was complete and speech was entirely lost. After a fortnight the movements were, little by little, completely restored. I will observe to you here that this hemiplegy may appear in a more dramatic manner, after a convulsive fit or a profound sleep, which then absolutely simulates the apoplectic stroke. In such cases, the diagnosis is very delicate; though the hypothesis of a hemiplegy and a hysteric sleep is difficult and rare, you must however think of it. Not long ago, I recognized an accident of this kind in a man sixty years old, who, at first sight, looked quite as if he had had an apoplexy.

The second severe and frequent form is *paraplegy*, in which both legs are completely paralyzed. This accident often appears when an individual is seized with an emotion while walking. It is about what English physicians call the "giving way of the legs." A young woman of twenty-five (what is strange is that she was a nurse, who, as such, ought to have known better) was one evening crossing a dormitory; she saw a patient in a crisis of somnambulism getting up and going about wrapped up in a sheet. She took her for a phantom, was terribly frightened, felt her legs shake under her and fell down without being able to get up again. She remained paraplegic for several months. You must also beware of these paraplegies after childbirths, and after somewhat long diseases in which the subjects have remained long in bed.

The third form will be monoplegy, which strikes a limb or a segment of a limb, for these paralyses may be very limited. With the painter I spoke of, it affected only the right wrist; in other cases it affects the articulation of the elbow, or the shoulder, the foot, or the whole of the leg. A long discussion, which is not yet quite settled, bears upon the existence of hysteric facial paralyses. Charcot denied them and maintained that what was called a paralysis of the right side of the face was nothing but a contracture of the left side. He only admitted in the face the existence of the glosso-labiate spasm. This opinion has been much contradicted and many cases of facial paralyses have been brought forward which seem to be typical. For my part, I do not see why paralysis of the eyelids, mouth, and cheek should not exist, and I have recognized some cases of this disease which seem to be convincing.

Lastly, there may be paralyses of the trunk, and I refer you to the most interesting, in my opinion, of the studies I have had the opportunity of making on this matter. The subject is a girl who had fallen into a well, and who, after this accident, presented a remarkable flaccidity of all the muscles of the trunk. She was quite unable to stand or sit, her head and body fell indifferently on every side. At the same time she had a remarkable paralysis of the diaphragm, on which we cannot insist for the present.[1] Such are the chief forms presented by hysteric paralyses. I must now somewhat insist on their diagnosis, which is of capital importance for you.

[1] Nevroses et Idees fixes, I, p. 328, II, p. 411.

II

The diagnosis of hysteric paralyses can be made in two manners. First, in an *extrinsic* manner, which was formerly considered as the more important. In this case you examine the symptoms that are foreign to the paralysis itself, the disturbances of the sensibility, the disturbances of the intelligence, the simultaneous phenomena, the circumstances of the appearance, etc. Secondly, you can make this diagnosis by an *intrinsic* examination, which chiefly takes into account the paralysis itself and its clinical characteristics. This second method appears nowadays to be more accurate and scientific and is often preferred. As I told you, the fashion nowadays requires that you should discover the curious little modifications of the reflexes which may characterize a paralysis without having to make any inquiry of the patient or those around him.

Let us then first give our attention to those intrinsic characters, since, at the present time, they are considered as more serious. You may first, in certain cases, take into account the localization and form of the paralyses. An Austrian author, Professor Freud, has insisted a great deal on this point. Hysteric paralysis never affects only one muscle, it is always a paralysis in a mass, which strikes a group of muscles. Do not suppose that every group of muscles may be thus affected. The group that is affected is always one that is necessary to a function of a part of the body. Yet the paralysis does not extend beyond the limit of

the muscles necessary for the functioning of this part of the body; it does not easily encroach upon other regions. It is otherwise in all organic paralyses; a lesion of a nerve may affect only certain muscles; a lesion of a nervous plexus affects several muscular groups. For instance, in the paralysis of the leg brought about by hysteria, the thigh and buttock are affected, but the sacral region and the genital region are intact, which is not the case in spinal paralyses. The same author remarks further that hysteric paralysis is often seated in the extremities of the limbs only, which does not happen in organic paralyses, the latter more often affecting segments that are near the centre.

Notice also that hysteric paralysis is exaggerated, always carried to an extreme, which is very rare in organic paralyses. A man whose hemiplegy is consequent on a cerebral hemorrhagy can still move a little, and makes some efforts to conceal his paralysis; one in whom hemiplegy is due to hysteria has no longer a shadow of a movement in his diseased side. Hence comes this difference in the gait which Todd and Charcot formerly pointed out, and for which they invented rather barbarous Greek words. The subject affected with organic hemiplegy, they said, has a *helicopode* walk; he walks helically, throwing his paralyzed leg sideways by a movement of his loins. The subject affected with hysteric hemiplegy has a *helcopode* walk; he drags his paralyzed leg in walking as if he did not trouble himself about it in the least, as if it no longer existed at all.

To these positive characteristics are added negative characteristics; hysteric hemiplegy is not accompanied

by any other serious disturbances in the diseased limb; in particular, there is no atrophy, or at least a very long time is required for it to appear after the period of immobility; so you must always carefully measure the two limbs of the patient. The existence of a notable atrophy will help you to recognize certain lesions of the medulla or brain. Nor are there any disturbances of the electric reactions; the reaction called reaction of degeneration, which is so rapid in certain forms of medullar lesions, does not exist in hysteric paralysis.

We come, at last, to the question of the reflexes, now considered as very important, chiefly, it must be said, on account of the studies of a French physician, M. Babinski, who has devoted himself to this subject. In a general way, all the reflexes of a limb must remain normal in a hysteric paralysis. This may easily be understood, since these reflexes depend for the most part on lower medullar or cerebral centres which are supposed not to be affected with any disturbance. On the contrary, in an organic lesion, a certain number of reflexes must always be injured, because the lesion always bears more or less upon one of these centres. You have first to consider the tendinous reflexes in the elbow, wrist, knee, tendon of Achilles. They must not be suppressed, as in tabes, nor exaggerated as in cerebral hemorrhagy or in the lesions of the pyramidal tract. You will seek, especially in the foot, for the epileptoid trepidation. The clonus determined by the sudden raising of the foot which appertains exclusively to the lesions of this pyramidal tract, does not exist in hysterical paralysis.

You will also examine the cutaneous reflexes; for instance, Babinski has shown the very important sign given by the toes, when the ball of the foot is slightly rubbed with a pin. In normal adults — for there are some irregularities in children — the toes bend together towards the sole of the foot. In the lesions of the medulla, on the contrary, you observe a raising and extension of the toes, but nothing like this can be observed in hysteria. Excitation of the skin in different regions of the body, on the internal face of the thighs, on the abdomen, on the neck, determine in a normal man contractions of the "peaucier" muscles, that is to say the muscles of the skin, which disappear in organic accidents and not at all in neuropathic phenomena. Don't forget to examine carefully the reflexes of the pupils to light, to accommodation; the slightest disturbances of these reflexes must put you on your guard. You know that the least alteration of these reflexes strongly inclines you to admit organic lesions, either those of tabes or those of syphilitic meningitis.

Lastly, Babinski has shown the importance of the preservation of the muscular tonus in hysterical paralyses. He insisted too with great accuracy on the preservation of certain unconscious movements produced by association in these apparently paralyzed limbs. This fact is analogous to the observation of the preservation of certain subconscious sensations in spite of hysterical anesthesia, that we have to study in the following lecture.

According to these authors, this ensemble of signs is absolutely characteristic, and it is possible to recognize a hysteric hemiplegy solely through this objective ex-

amination which requires nothing of the patient's psychological observation. The thing is perfect theoretically, but practically it is much more difficult than is supposed. Most of the signs we have spoken of, when treating of the localization of paralysis, either are indecisive or apply but to quite particular cases.

The signs of the reflexes are much more important, but can we absolutely trust them? First of all we must eliminate the signs derived from the mere exaggeration of the tendinous reflexes. You cannot eliminate hysteria merely because a patient throws his leg upward too strongly after the shock of the rotular tendon, for this exaggeration of the reflex is exceedingly difficult to appreciate and very irregular. A very great number of subjects, when a little moved or nervous, throw their legs too strongly upward when their knee is struck. It may be said that one should distinguish the real reflex, which is quick and simple, from the semi-voluntary, semi-emotional movement which is added to it, and which is too tardy, too long, too much generalized. All this is true enough, but, in practice, I defy you to make the distinction, and moreover I am inclined to believe that in hysteric and neurasthenic patients there is often a real exaggeration of the reflexes, which is perhaps due to a diminution of cerebral inhibition.

The sign of the clonus of the foot has more importance. The significance is much discussed at the present time, and several authors point out cases of unquestionably hysteric paralyses in which it has been met with. Some authors maintain that if they take the graphic of the shake with the registering apparatus, they recognize the

regularity of the organic clonus in contradistinction to the irregularity of the hysteric clonus. But this is not quite certain.

Babinski's sign of the toes is exceedingly interesting. In reality, you need not hesitate when it manifests itself clearly; I don't think it has yet been distinctly observed in a hysteric paralysis. But it is an irregular sign, which often fails totally. Many subjects do not react at all or react by a retraction in a mass of the leg. The pupillary reflexes are likewise of capital importance; be always on your guard when you meet with the sign of Argyll Robertson. But this sign is not absolutely characteristic either; first of all, many neuropathic patients have pupillary dilatation, then, in some hystericals, there are contractures of the iris with dilatation or myosis, which prevent the reflexes from taking place easily and may again be causes of error.

In a word, it is certain that the intrinsic examination gives us exceedingly valuable indications. The invasion of the face, the disturbances of speech, the clonus, the signs of the toes, the pupillary disturbances are strongly in favour of an organic lesion. Unfortunately they are not absolutely certain signs, and I think one is quite wrong in making things more difficult than they are, in refusing the unquestionable services rendered to diagnosis by much more characteristic extrinsic signs.

III

The most important extrinsic sign of all is derived from the examination of sensibility, the modifications

of which are of the greatest importance in hysteria. We already met with them when studying choreas and contractures; we observed that the hysteric patient often appears not to know what is going on in her arm or leg, that she does not feel the fatigue of her protracted shakes or contractions, and that, what is more, she may not feel the movement of which her arm is the seat. This anesthesia is still more characteristic in paralyses. We must therefore insist now on its study.

For a long time physicians had had some vague notions about the odd insensibilities of these patients. You know that in the Middle Ages people recognized witches and possessed persons by seeking on their bodies for what was called the claw of the devil. It was a more or less extensive part of the skin in which the subject was insensible to any touch or prick. The expert entrusted with this work would close the eyes of the subject, and, armed with a sharp needle, prick here and there the different parts of the body. The sufferer was to answer with a cry to each prick, and the claw of the devil on a certain spot was recognized from the fact that he did not cry when this spot was examined. Later on, Sydenham, in 1681, then Louyer Villermay in 1816, Georget in 1824, Landouzy in 1846, later still, Briquet, Charcot, and all the modern authors have strongly insisted on all the varieties of this phenomenon.

For the present we shall attend to the indications that anesthesia can give us as regards the diagnosis of hysteric paralyses, and especially to its seat and depth. This insensibility must be sought for this purpose in three organs, on the skin, on the mucous membranes,

and in the muscles. It may indeed extend either over the cutaneous coat of the limb, or over the accessible mucous membranes of the natural orifices, or it may bear upon the sensations of motion and upon the notion of the position of the limbs. In the first case, we have to examine the skin and mucous membranes as regards contact by passing our finger or a blunt instrument over them. We may hope to obtain more accurate results by the use of the æsthesiometer, which shows us how the subject recognizes the differences of sensation depending on the different spots of the skin. You will examine on these same regions the temperature-sensations by alternately applying on the skin, unknown to the subject, a cold and a warm object; lastly you will examine the sense of pain by pinching, by sticking in a needle, or by using one of the various algesimeters. You will thus find that these various sensibilities may completely disappear, either simultaneously or separately. It is not rare to find absolute insensibility of the skin accompanying hysteric paralysis.

You will then examine the so-called muscular sensibility by displacing the limb in different ways and asking the subject to describe these positions and movements without looking at them, or better still, to reproduce them with his uninjured arm. Here again you will often find in hysteric paralyses complete insensibility to position, the subject no longer possessing any information about his diseased limb.

The existence of such anesthesias already gives you an important piece of information. No doubt anesthesia exists in organic lesions, but it is much rarer

and, in general, not nearly so deep as in hysteric affections. Further, it is easy to acknowledge that the anesthesia when it is connected with hysteria presents certain characters that are not to be found when the insensibility depends on organic affections of the nervous system.

One of the characteristics of this anesthesia, and one that plays a most important part in the diagnosis, has been well illustrated by Charcot and nowadays still appears to us to be very significant: the *localization* or *the place of this insensibility*. Charcot used to say that in hysteric paralyses anesthesia takes the form of *geometric segments*, meaning that it is terminated by distinct, regular lines assuming definite forms which can be foreseen. Of course, when the hemiplegy is complete and the hemianesthesia is also complete, the form is very clear, but has no great significance; it stops just at the median line of the body, dividing into two equal parts the forehead, nose, mouth, breast, and abdomen (Figure 8). This section is curiously regular; on the one side, the skin is absolutely insensible, as well as the

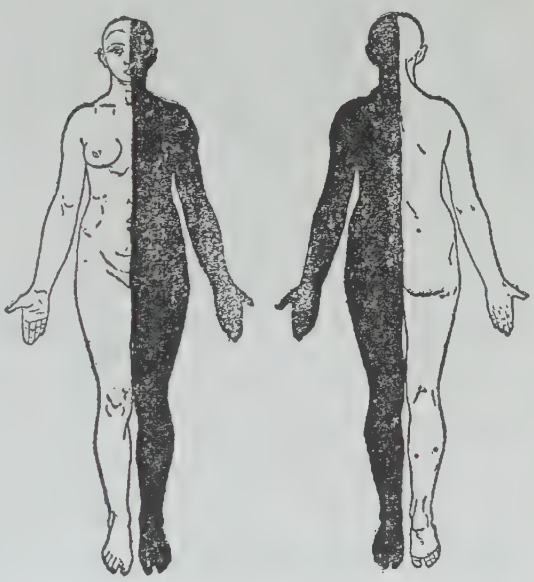


FIG. 8. — Schema of hysteric left hemianesthesia.

mucous membranes and, as we shall see later on, the organs of the senses. On the other side, the sensibility is intact. You may barely observe some transition, some degradation on the median line of the body. On one side, the subject feels nothing; on the other, she feels quite normally. It is true even of the mouth and tongue; the separating line is found on the palate and tongue. This hemianesthesia exists also in certain forms of organic lesions, in certain lesions of the internal capsule; one may at most say that it is rare, and that, in general, the separation is not so clear, that there is a broader line of demarcation, with confused sensibility. One may say, too, that usually the troubles of sensibility are more severe in the extremities than at the root of the limbs, instead of being regularly the same in all the parts as in hysteria. But, of course, in this case the form of the anesthesia will not give you much information.

In the other paralyses, the form of the anesthesia is more instructive; it seems to terminate precisely enough, above the paralyzed organ by a nearly circular line traced by the plane perpendicular to the axis of the limb. Thus a paralysis of the hand brings about an anesthesia of the hand extending up to the wrist and terminated by a line in the form of a bracelet (Figure 9); an anesthesia of the whole of the arm is limited by a line including the shoulder, passing a little under the arm-pit, in the form of a jacket-sleeve, as Charcot used to say. A paralysis of the foot brings about a sock or a stocking of anesthesia. A paralysis of the leg gives birth to an anesthesia in the form of a leg of mutton,

which generally spares the anus and the genitals (Figure 9).

Now these forms of anesthesia, which look so simple, are particularly extraordinary from a physiological point of view. They by no means correspond to the distribution of the nerves or even of the nervous plexuses. You know that the hand is innervated by three principal nerves, the radial, the median, and the cubital. A section of one of these nerves brings about a well-known anesthesia of anatomic form corresponding to the distribution of the nerve. You know, for instance, the old anesthesia of the lesions of the cubital, which only affects the little finger and the longitudinal half of the fourth (Figure 10): it is not at all like our geometric segments in the case of a paralysis of the hand. A lesion of the brachial plexus anesthetizes only a part of the arm, and the limit of the anesthesia affects a special form, because it reserves the sensibility of a portion of the shoulder above the deltoid, which is innervated by the cervical plexus (Figure 11). A lesion of the sacral plexus brings about, it is true, the anesthesia

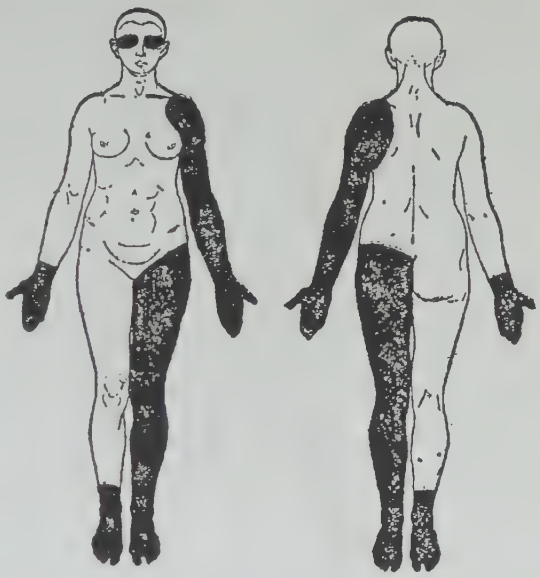


FIG. 9. -Schema of various forms of localized hysteric anesthesia.

of the thighs on their internal face, but affects the anus and the genitals. On this distribution of the insensibilities and on the places of the reserved regions is founded the anatomic diagnosis of the lesions of the nerves and of the tumours of the medulla. But it is

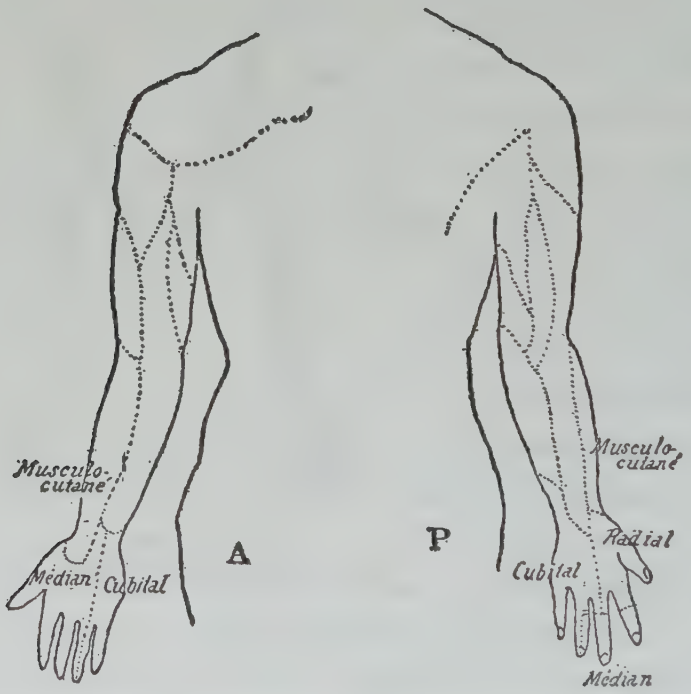


FIG. 10.—Cutaneous territories of the peripheric nerves in the right arm. A, anterior face; P, posterior face. (See Dejerine, "Semiologie du Système nerveux," in "Traite de Pathologie Generale," V, p. 952.)

not possible to connect the forms of anesthesias we just observed in the hysteric paralyses with these forms given by the organic lesions.

This difficulty of localization was so great that Briquet tried to make other hypotheses and asked himself whether the distribution of hysteric anesthesias did not depend on the vascular circumscriptions, on the cir-

culation of the blood, more than on the nervous circumscriptions. Now we see that such is not the case, there is no arterial irrigation in the form of a wrist band, a jacket sleeve, or a leg of mutton. This form of anesthesia is something quite peculiar.

I have tried formerly to sum up these localizations of hysteric anesthesia by a word that has had success; the hysteric patient, I said, seems to attend to the popu-

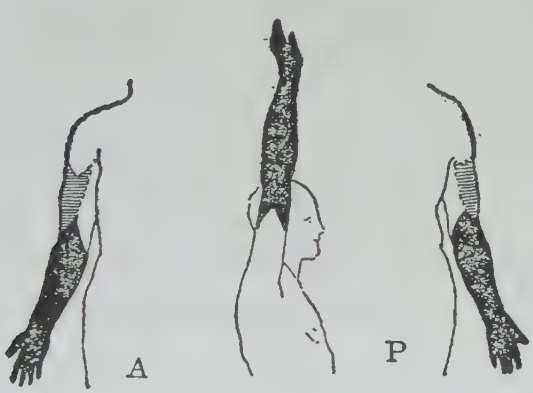


Fig. 11. — Localization of the anesthesia in a case of a lesion of the brachial plexus. Id., ibid., p. 951.

lar conception of the organ rather than to its anatomic conception. For the common people, what is an eye? It is the ensemble of the organs that feel the orbit, eyelids included, and, in fact, the hysteric person who has anesthesia of the eyes has on her face, as it were, a pair of spectacles of anesthesia (Figure 9) affecting the two eyelids in their central part. For the common people, the hand terminates at the wrist. They don't care if all the principal muscles that animate the hand and fingers are lodged beyond in the fore-arm. The hysteric person who paralyzes her hand seems not to know that

the immobility of her fingers is due in reality to a muscular disturbance in her fore-arm. She stops her anesthesia at the wrist, as would the vulgar, who, in their ignorance, say that if the hand does not move, it is because the hand is diseased. Now this popular conception of the limbs is formed by old ideas we have about our limbs, which we all keep in spite of our anatomic notions. So these hysteric anesthesias seem again to have something mental, intellectual, in them.

This characteristic, though really very important, might still, however, give rise to some cavilling. There are in intoxications, in alcoholism, for instance, insensibilities in the form of a sock or a boot. In the medulla, segmental localizations have been studied that may lead one to conceive anesthesias of the same kind. Practically, you will be right nine times out of ten in basing a diagnosis of hysteric paralysis on this geometric form of anesthesia, but, in order to avoid the least chances of error, we must insist on the last characteristic, to which we have just come, namely the mental character of this anesthesia. It is, moreover, this character which will enable us to arrive at a more intelligible conception of the paralysis itself. Such will be the object of our next lesson.

LECTURE VIII

THE PSYCHOLOGICAL CONCEPTION OF PARALYSES AND ANESTHESIAS

The problem of hysterical anesthesias — Absence of any modification of the reflexes, of any physiological disturbance — Indifference of the patient — Mobility of the anesthesia under various influences, attack, sleep, intoxication, somnambulism, suggestion, emotion, and above all attention — Contradictory character of this anesthesia — The part played by absent-mindedness — The dissociation of certain groups of sensations in the anesthesia — The indifference, the lack of representation and memory in the paralysis — The astasia-abasia — The systematic paralyses — The dissociation of a system of movements — The system of movements and sensations in a function — Hemiplegy and paraplegy as dissociations of functions

THE time has now come to give our attention to some psychological studies on hysteria that had a great development in France about twenty years ago, and have contributed much to the development of pathological psychology. They are perhaps rather special, having perhaps a less general importance than we then thought, but without them we could not understand the particular nature of hysterical anesthesia, nor even perhaps form with sufficient clearness a general idea of the hysterical disease itself and especially of the paraly-

ses that exist in this disease. We shall insist on the mental characters of anesthesia, and try to derive from them a general conception, and then we shall see that it finds its application in the study of paralyses, which we shall take up again from a new point of view.

I

We have already seen that hysterical anesthesia presents certain oddities which ought to attract the physician's attention. It is accompanied by a very deep and even exaggerated paralysis, and yet does not determine any serious objective disturbance. Is it not odd to see a limb remaining quite insensible, quite paralyzed for months and sometimes years together without any serious atrophy, without any modification of the electric reactions and, above all, without any change in the reflexes? Certain reflexes in particular astonish us very much; the reflexes of the erectile organs, those of pain remain intact. You know, for instance, that if you determine a strong pain by pinching the skin at any point whatever of the body, the pupils contract suddenly. This fact persists with our hystericals who declare they feel nothing. The vascular reflexes in relation to the sensations of cold and heat are very delicate. M. Hallion recently contrived to study them with great accuracy by means of a delicate little apparatus which he invented. The application of a little ice on the fore-arm immediately brings about the contraction of all the vessels of the hand. At my request he was so kind as to study the fact with my

patients, and found that the most anesthetic hystericals reacted quite correctly in this respect.

Besides, we know quite well what the disappearance of the cutaneous sensations produces, in practice. Physiologists have shown that when the limb of an animal is made insensible by the section of the sensitive root, this limb, quite intact at first, cannot, nevertheless, be preserved; it is not long in becoming unclean and covered with sores, and it disappears little by little, for the animal itself bites it off. Sensibility is a safeguard for our limbs. We may observe the fact in a well-known disease. You know those patients who come to the consultation to complain that their hands are constantly burnt or wounded. They have scars of burns on their fingers and are not able to avoid this accident. They are syringomyelic patients and the lesion of their spines makes them insensible to cold and heat. Why is there nothing of the kind to be found in our anesthetic hystericals?

This absence of objective disturbances is mostly accompanied by a very curious subjective symptom; namely, the indifference of the patient. When you watch a hysterical patient for the first time, or when you study patients coming from the country, who have not yet been examined by specialists, you will find, like ourselves, that, without suffering from it and without suspecting it, they have the deepest and most extensive anesthesia. Lasegue, who analyzed very carefully many of the subjective characteristics of hysteria, has often pointed out this ignorance among the patients. Charcot has often insisted on this point and shown that

many patients are much surprised when you reveal to them their insensibility. Recent authors are also agreed on this point. It is far from being the case with anesthesias of organic origin. That particular symptom of tabes, which Charcot was one of the first to describe and which he has called the tabetic mask, is well known. The patients lose the sensibility of a part of the face, more or less extensive, but they account for it subjectively, and declare that they experience a horrible feeling in regard to it. Ask hystericals who have facial anesthesia — and they are legion — whether they experience a horrible feeling about it, and they will all tell you that they do not care.

To explain precisely this important difference between hysterical anesthesia and anesthesia of organic origin, it will not be out of place, we think, to relate a little anecdote. We did not obtain it ourselves, but it was given to us by our brother, Dr. Jules Janet. When he was house surgeon at the Pitie with Dr. Polaillon, he had an opportunity to observe the following case: A young girl of about twenty had met with a rather serious accident. She fell through a glass door, and a piece of glass cut into her right wrist just below the thenar eminence. The hemorrhage was stopped, and the wound had united fairly well when, a few days after the accident, the young woman presented herself for treatment. She experienced a certain numbness in her right hand, but no paralysis was present. She complained particularly of a persistent insensibility, most inconvenient, in the palm of the hand; this slight anesthesia about the fingers was in fact complete at the level of the thenar eminence.

The case was evidently one of a more or less complete severing of the median nerve, and especially of its superficial branches. But while accepting the observation of the patient, we made a singular discovery. She was a hysterical, and on her entire left side she was completely anesthetic, of which fact she had not said a word. The physician joked her about it: "How is it, miss, that you come here complaining about an insensibility that affects but a small portion of the palm of your right hand, while you do not even notice the much larger insensibility of the whole of your left side?" The poor girl looked surprised and ashamed. To our mind she might have replied to her doctor with much more assurance, and said: "Be that as you think, sir, I came here to tell you what ails me; it is the insensibility of the palm of my right hand that troubles me, and that of my left side has never given me any trouble. You are the doctor; explain it as you like."

To these general remarks must be added all that we have already said on the form of these anesthesias, a form which has nothing anatomic or even scientific in it and seems to correspond to false popular notions. These remarks compel us to enter more deeply into the scrutiny of the mental state corresponding to these strange insensibilities. This study leads us now to point out a new characteristic in the same order of ideas, namely, the remarkable *mobility* of these anesthesias.

Unquestionably, some patients retain their stigmata all their lives. Aurel. is still hemianesthetic at seventy-five; Ler. has kept a hemianesthesia and a contraction

of the visual field for forty years. We shall have to keep an account of these cases; but generally, and perhaps even among these very patients, without its having been observed, anesthesia becomes modified and disappears all at once for longer or shorter periods. It varies from one moment to another, says M. Fere, and under the influence of causes so slight that they may pass unnoticed.

However rapid in their mobility, some of these changes may nevertheless be studied, and one can note at least some of the circumstances in which they are oftenest affected. The attacks modify considerably the localization of sensibility. Many authors have noted that anesthesias often increase at the time preceding the attacks. For example, Marguerite X., who ordinarily has right-sided hemianesthesia, becomes, during the hours that precede the attack, totally anesthetic. We point out a case much rarer still; it is an opposite phenomenon. Cel., usually totally anesthetic, recovers complete sensibility sometimes during a form of excitement which lasts half an hour before the attack.

During the attack itself, when we can obtain some intelligent sign (we have seen that it is generally possible), the sensibility becomes modified. Often, as happens with Bert., it is recovered entirely. After the attack, many patients, like Marg., return to their usual condition; others have for some time anesthesias more extended than usual. Bert., generally hemianesthetic on the left side, remains, after the attack, totally anesthetic and at times completely blind for some hours.

It often happens, during natural sleep at night, that tactile anesthesias disappear. It is very difficult to verify the fact. We have to take the patients by surprise at night, using all sorts of precautions not to wake them. We pinch them on the anesthetic side. They groan, turn over, complain in their dream, or wake suddenly, exactly as a normal person would. M. Jules Janet, when he was an assistant of Dumontpallier, has repeatedly verified this fact on two patients, the observation of which he communicated to us. We had the fact established on various persons, particularly on Bert. and Is. Our friend, M. Dutil, was kind enough to verify the fact for us on a hysterical, G., hemianesthetic on the left side. Pinched on that side during her natural sleep, she winced and spoke in her dream: "You are pinching me — how stupid —"

During certain intoxications that bring with them states analogous to sleep, insensibility vanishes more or less completely: many patients, totally anesthetic, become entirely sensitive when drunk. Chloroform-anesthesia in the period of excitation does away with all stigmata, with the anesthesia as well as the contractures. "Among the most paradoxical consequences of the hypodermic use of morphine," says Mr. Ball, "we must cite the restoration of cutaneous sensibility with subjects who have lost it. . . . A hysterical, drugged with morphine, a dose of eight centigrammes a day, felt all her pain disappear and her normal sensitiveness restored. Abstinence brought back her hysterical symptoms." The same fact has been described by M. Jules Voisin. In the same manner we see often

a diminution of the anesthesia and a widening of the visual field in hystericals who are under the influence of morphine, and we could verify too the reappearance of the anesthesia after the cessation of the influence of the drug. Many other excitations must have analogous effects.

The object of our first work [1] was, above all, the numerous modifications of sensitiveness during states of induced somnambulism. Certain subjects, under rare conditions, recover suddenly and completely all their sensitiveness as soon as they are in the second state. This fact has been sometimes pointed out in old descriptions of the magnetizers. We have very often established these same facts at the outset of our researches before we had read the very interesting observations of these authors. Sometimes the subjects have, during their somnambulism, an anesthesia apparently general; but the slightest excitation that directs their attention somewhat upon tactile sensitiveness causes this anesthesia to disappear, even on parts that remained anesthetic when awake, despite suggestions. This restoration to sensitiveness of some subjects proceeds somewhat slowly and becomes evident only when the hypnotic state has been considerably prolonged. Others again have a more complicated somnambulism; they pass through several states in which sensibility and, above all, memory undergo many modifications. It is only in one of these states, often a state that develops after all the others, that the subjects recover all their sensibilities.

[1] "L'automatisme psychologique," 1889.

Sensibility may be modified even in waking time. Briquet has insisted on the action of electricity; Burcq and many others after him have shown that magnets, metal plates, and many other agents, which all vary according to the patients, have analogous effects. The sensibility, increased by these agents, persists for a longer or shorter time and disappears with oscillations.

The influence of suggestion, in general very powerful with hystericals, may suffice momentarily to reestablish the sensibility, but it should be borne in mind that this phenomenon is far from being general, that, with a number of patients, sensibility changes very little when it is suggested, and on the contrary undergoes great modifications under the influence of certain excitations, such as drunkenness, or certain changes of psychological state, as somnambulism.

Many other psychological phenomena come in to produce, modify, or destroy anesthesia. For example, strong emotion, preoccupation, reveries, increase it. The association of ideas may in some cases modify it. We say to one patient that she has a caterpillar on her left hand, and she cries out and pretends that she feels the tickling of it; at this moment the whole of her left arm has become quite sensitive.

But there is a psychological phenomenon which plays a far more important part than any other, and its study throws a great deal of light upon the problem; we mean attention. To verify this fact, we must remember, as we shall demonstrate later, that with hystericals attention is altogether the most difficult thing to fix, and that only a few can succeed in directing it. As a gen-

eral thing, we may for a moment attract their attention upon their anesthetic hand by whatever means we please. A patient does not feel the electric current when he has his eyes shut. He acknowledges a tickling on seeing the manipulation of the process. We fasten a red wafer on Bert.'s left hand, she looks astonished and stares at her hand. Let us leave her for a moment; then, when her head is turned, let us lightly pinch that hand, so insensible but a moment ago. Bert. now cries out when we pinch her and feels it quite perfectly. It is true that this fine sensibility will not last long. We take that wafer off and a few minutes later she can no longer feel anything. All these phenomena, the last particularly, are the origin of many difficulties, for they very easily upset the sensibility that is the object of the study. They increase the anesthesia, they fix it, or suppress it; they give it an extremely changeable aspect, which discourages the observer.

Now it will be asked, does the anesthesia, at least as long as it exists, present itself to the observer definitely? Is it always very certain, in whatever way you examine the subject? By no means; and we have to point out a second series of observations which complicate the problem of anesthesia still more, for they present it to us not only as changeable, but as *contradictory.*

Lasegue said in 1864 that hysterical anesthesia looked strange, and that it seemed to be a psychological perturbation, a sort of alienation. The studies which subsequently confirmed this theoretical conception were at first observations on an altogether special point,

namely, on unilateral amaurosis; that is, on certain very interesting disturbance of the vision, about which we shall speak in our next lesson.

If the unilateral amaurosis presents embarrassing problems, it is the same with all anesthesias. Several years ago, we made the following observation of a patient in M. Powilewic's service at the Havre hospital. She was attacked with hysterical paraplegia and presented a state of total anesthesia. We used to treat her legs with electricity, and noticed the strong muscular contractions she experienced at each contact of the negative electrode, when all at once we saw that the two wires which fastened the plugs to the apparatus had dropped. For a long time we had thus been applying electricity with mere pieces of wood. We continued without fastening the wires to the ends, and the contractions were all the greater by the simple contact of the plug. This, it will be said, is nothing very wonderful; there is a sort of habit in that a suggestion is taking place. We think so too; but how could this patient, whose skin all over her body was wholly insensible, and with her head well turned away, feel the moment when the plug touched her legs, and make a movement just then and only just then? We may every day experience a similar embarrassment. We propose to Is. a little contrivance to verify her anesthesia quickly. She is to answer "Yes" when she feels and "No" when she does not feel anything. As she is very simple-minded, she accepts without demurring, and we discover then a curious contradiction. Although she has her eyes carefully concealed behind a screen, although

we avoid any kind of rhythm and pinch her several times irregularly on the same side before we pass over to the other, she is never mistaken, and always says "Yes" when we pinch her on the left and "No" when we pinch her on the right. The same experiment repeated on a man, Pasq., gives exactly the same results, until he perceives the queerness of his answers and tries to answer attentively. He then ceases, but only then, to say "No" when we pinch his anesthetic side.

Here now is another observation which bears no longer on the tactile but on the muscular sense. A young woman, twenty-two years old, whom we have often described by the name of Lucy, took during her attacks certain cataleptic poses. For an hour, she would keep her eyes fixed on the window and her arms raised in an attitude of terror. For the present we must insist on only one detail of this attack; we observed that during the most normal of her waking states, it was enough to raise both her arms, and place them in the posture of terror which they took during her crisis, to induce at once an attack. Of course, you will say the thing is quite simple and well known. By the position of the arms you call forth the principal idea of attack, and the rest follows. True, but there is a little detail yet. Lucy was anesthetic over her entire body and presented nowhere any trace of muscular sense. As often happens in this case, she would fall down at once as soon as you closed her eyes. Now, we have often taken the precaution to close her eyes before displacing her arms, and the crisis occurred all the same as soon as the members had the required posi-

tion. How do you explain the notion of that position being appreciated by so insensible a subject? All these facts and a great number of others which have been accumulated are very likely to puzzle the observer. They show us that hysteric anesthesia not only changes from one moment to another, but, indeed, varies in the same instant and manifests itself by contradictory phenomena according to the questions put to the subject.

II

We must rapidly lay aside a first interpretation of these facts. The anesthesia of hystericals is extremely changeable and contradictory. These patients pretend not to feel, and by very simple artifices we can prove to them that they feel perfectly well. Their insensibility is, therefore, simulated, and our processes are only means to deceive a deceiver and unmask a fraud. This *resume* of facts is, to our mind, altogether crude and insufficient. Do hystericals take any particular interest of pleasure in having their arms pierced through with needles? Do these young girls pass through the council of revision to simulate unilateral amaurosis? How is it that, in all civilized countries, hystericals should have agreed to simulate the same thing ever since the Middle Ages to the present day?

We must not be content with this crude explanation, and since anesthesia presents itself to us as a psychological fact, we must seek, among the few notions psychology furnishes us, that which best summarizes facts of this kind. We are happy to have Lasegue

confirm an opinion which we have maintained for several years; hysterical anesthesia is a certain species of absent-mindedness. "A person," said Lasegue in 1864, "absent-minded through a great preoccupation, does not perceive sensations which, in another frame of mind, he would scarcely have tolerated. . . . It is probable that hystericals, whose moral state offers so many other singularities, acquire likewise, through their very malady, a sort of laziness that renders them less apt to perceive certain psychic modalities."

This explanation based on absent-mindedness is, in reality, but a first approximation. Anesthesia is surely not ordinary absent-mindedness; it has much more clearness and duration. It is far from disappearing so easily as soon as the subject chooses, and above all, it appears without there being any fixed idea of any object which attracts the patient's attention to another point. There is in it a pathological incapacity to collect the elementary sensations in a general perception. In reality what has disappeared is not the elementary sensation, the preservation of which we have just seen; it is the faculty that enables the subject to realize this sensation, to connect it with his personality, to be able to say clearly: "It is I who feel, it is I who hear."

We shall often have the opportunity to reconsider this problem, but let us remark, by the way, that this singular character of anesthesia is not unknown to us; after all, we have already seen something similar while studying the amnesias that follow somnambulisms. I have already told you that the subjects were unable to remember what had happened during the fit of

somnambulism, and even to remember the principal idea which played a part in this state. Irene, whom I have repeatedly spoken of, had forgotten after the crisis not only the comedy she had played but also her mother's death and illness, which were its starting point.

We accepted at that moment, without discussing it, the description of this amnesia, for we did not want to complicate the matter, but in reality that oblivion was very strange. Was it real oblivion, the obliteration of the recollections, the destruction of the images? By no means, since the patient could be cured and is now able to relate clearly all those events. Was it then the inability to reproduce them? Was it that the brain, while keeping their traces, was nevertheless not able consciously to cause them to reappear? By no means, since the patient had dreadful fits every day during which she recited all the details of the events. In a word, she had forgotten nothing and she had the power to recite everything. Then where was the oblivion? The oblivion consisted only in this, that she could not recite in a waking state, with full consciousness of the other events and of herself. She could relate, it is true, but in a dream, in a delirium, without having at the same time the notion of herself. As soon as she had the personal consciousness of her name, of her situation, she could no longer associate the remembrance in question. We tried to sum this up by saying that somnambulism is not the destruction of an idea but the dissociation of an idea, that has emancipated itself from the ensemble of consciousness, and that the ensemble of consciousness can neither recover nor control.

Well, our anesthesias, which looked so strange, have just presented to us the very same characters with more clearness still. They are groups of sensations forming a kind of system, that is to say the ensemble of sensations coming from the hand or the leg, which can no longer be connected with the totality of consciousness, although they still exist on their own account and even determine reflexes and usual movements.

Let us apply the same notion to our paralyses; we shall see that the facts are absolutely of the same kind. Besides anesthesia, on which we dwelt for some time, there are other mental phenomena which accompany hysterical paralyses. The most curious are connected with a kind of indifference, analogous to the one we remarked in anesthesia. If we had a paralyzed arm, it would inconvenience us exceedingly, we should fret very much about this disease, we should perpetually regret our former state and be forever making desperate efforts to recover the motion we had lost. We cannot help therefore being somewhat surprised and ill-humoured when we attend a paralyzed hysterical. This kind of patients vexes us with their calm indifference and inertia. One of their limbs being out of use does not appear to incommode them; they think it quite natural to walk with but one leg, and do not make the least effort to use the other leg. It was just this that determined the famous distinction Charcot made between the helicopode and helcopode gaits. While the person affected with organic hemiplegy labours hard to move his restive limb forward, the hysterical drags hers after her like a cannon-ball. She almost despises it, and

she wants to beat it, calling it "an old stump," like a patient Professor James has described.[1]

This conduct corresponds to a very special mental trouble. If you question such persons, you find that they seem not to have kept the remembrance of their limb, they do not know any longer what this paralyzed limb used to do and they can no longer make the efforts of imagination necessary to conceive it. Fere was one of the first who insisted on this point. "After having shut the patient's eyes," he says, "I ask her to try to represent to herself her left hand executing movements of extension and flexion. She is not able to do it. She can represent to herself her right hand making very complicated movements on the piano, but on her left, she has the sensation that her hand is lost in empty space. She cannot even represent to herself its form.[2]" I have verified this remark more than twenty times. This lack of representation and memory of the paralyzed limb is one of the most typical things; many authors have remarked it. Here is the statement of an English author, Dr. Bastian, who, by the way, has quite another conception of hysteria than we; "When I ask her if she can imagine that she touches the tip of her nose with her left finger, she immediately answers: 'Yes.' If I ask her to imagine the same movements with the paralyzed hand, she remains hesitating and at last answers: 'No.' She can imagine herself playing on

[1] William James, "Notes on Automatic Writing." *Proceedings of the Society of Psychical Research*, March, 1889, p. 552, and in "The Principles of Psychology," 1890, I, p. 377.

[2] Ch. Fere, "La Pathologie des Emotions," 1892, p. 143.

the piano with her left hand but not with her right hand."[1]

The same remark applies to the old observations made at the outset on the will of these patients. The English author Brodie had already said: "In hysterical paralysis, it is not the muscles which do not obey the will, it is the will itself which does not enter into the action." W. Page added: "When the patient says: 'I cannot,' it means, 'I cannot will';" and M. Huchard said: "They cannot, they will not will." What did these remarks, applied to paralytics, mean? They meant that the patient did not seem to make the initial effort, to apply his consciousness to a certain act. He did not even seem to have the representation of this act. All these remarks are of about the same kind, and we find again in paralyses dissociations of psychological phenomena identical with those we have observed in somnambulic amnesias.

There is but one difficulty left. What is the psychological phenomenon that dissociates itself? In somnambulism, it was the idea of an event, and was relatively clear; but have we in our mind the idea of the motion of our two legs? Is it this idea that disappears in its entirety and makes us lose the motion of our legs? It seems very odd, and we are not accustomed to apply the word idea to the ensemble of the movements of our two legs. To make the thing clear, we must now recall certain forms of paralyses of which I have not yet spoken and which will, I think, form the transition

[1] Charlton Bastian, "Various Forms of Hysterical or Functional Paralysis," 1893, p. 15.

between the preceding phenomena of dissociation and the great paralyses which we do not understand.

III

Several authors, one of the first of whom was Jaccoud, and among whom we find Charcot, Blocq, and Seglas, had pointed out a form of hysterical paralysis still more extravagant and unintelligible than the others.

The subjects are, as a rule, young people; they seem not to have the least paralysis of the legs, when you examine them in their bed. Not only are the reflexes intact, but — and the fact is more surprising — the movements are intact. If you tell them to raise their legs, to bend, to turn them, they do exactly all that is required of them. What is more, they have kept a very great strength, quite the normal strength. They push back your hand with their feet, they lift you up if you bear down with all your strength on their knees. Then, you will no doubt say, there is nothing at all the matter with them. It is true, but they are absolutely incapable of walking. If you cause them to stand on the floor, they will bend, twist their legs, throw them to one side and the other, and fall down without having made one step: and this will last for weeks and months. They realize the paradox of having no paralysis of the legs and of being unable to walk. In a few, described by Charcot, the comedy is still more complete; they are able to make with their legs certain movements which seem very complicated, as jumping, dancing, hopping on one leg, running, but they fall as soon as they try to walk. Can you conceive such an absurdity?

For some time this disease, which was called *astasia-abasia*, seemed to be almost alone of its kind, but soon physicians were obliged to recognize that there were many other paralyses belonging to the same type, and that they were even frequent. Some subjects are still able to walk, but cannot stand; others have lost some functions of the hands: they almost always forget their trade; a needle-woman can no longer sew, an ironer can no longer handle an iron, though they have no paralysis of the hand. Frequently girls can no longer write at all, or play on the piano. M. Babinski has shown such cases for the functions of the mouth; the patient can no more blow or whistle, while he can make all the other movements of the lips. These examples are sufficient to prove to you that there are very often *systematic paralyses* in which a certain system of movements, grouped by education, separates from consciousness and takes an existence of its own.

These phenomena come much nearer to our somnambulic amnesia. The oblivion of her mother's death which came upon one of our patients, and of all the care she had taken of her during her illness, was the loss of a system of images and movements which comes very near the oblivion of sewing or writing. You understand that in these two cases, the group and the more or less complex system are of the same kind. Well, if it is not too bold, I will propose to you, not to consider abasia as an exceptional hysterical paralysis, but on the contrary to make it the type of all the other hysterical paralyses.

The ensemble of the movements of the right hand is

a system of images and movements, exactly as the ensemble of the movements necessary to play on the piano. Only it is a much more extended and, above all, a much older system. It is the reason why it contains in itself and involves all the sensations of the hand, whereas playing on the piano involved only certain special sensations. And what about the paralysis of the two legs? you will ask me. It is, in my opinion, exactly the same. The two legs form a unity, not only anatomically but especially, psychologically speaking. Our ancestors, the animals, contructed in their mind the association of the limbs of the same level, of the same segment. These limbs have a common role to play: such a segment enables us to stand, such another to seize objects. This system of images relative to the two legs is very vast; it contains subdivisions, as the system that concerns walking, or jumping, but it can be dissociated in its entirety. Lastly, since we are making hypotheses, we must not stop half way; hysterical hemiplegy is a phenomenon of the same kind as astasia-abasia. The movements of one side of the body also form a system: we have a very clear idea of the ensemble of the actions of the right side as opposed to the ensemble of the actions of the left side.

No doubt, you will tell me, these great systems of sensations and images are at the same time anatomical systems, which have a unity in the brain and in the spine. I do not deny it by any means; the fact that a system is psychological should not cause us to conclude that it is not at the same time anatomical. On the contrary, the one involves the other. When I begin to

learn to ride a bicycle, I voluntarily group together images depending on several centres and which have never been grouped: consequently I am very awkward. After some time, I can maintain my equilibrium on a bicycle; it means that these different images have associated together and regularly call forth one another. It is very likely that this functional association corresponds to an anatomical association which has been effected among the different centres, and that a new little centre has been formed in my brain, the centre concerning bicycle riding. It is even because this centre persists and develops, that next year I shall be able to ride without learning again. With regard to new functions, we understand easily that the system is at once mental and physical; but you should impress your mind with the belief that your ancestors, the monkeys, learned to walk on two legs as you have learned to ride a bicycle, and that, before the monkeys, there were other beings who learned to systematize the movements of one side of their body and invented the right side and the left side. This very old function has well organized centres, but it is none the less a function, that is to say, a complete system of sensations and images.

Well, as the hysterical may lose, while they have fits of somnambulism, a little system of thoughts that emancipates itself, which loss brings on two symptoms, somnambulic agitation and amnesia, so the same patient may, in the same way, lose through dissociation a great and old system of thoughts and sensations, that of the right side or that of the two legs. And this new dissociation will again manifest itself by two great symp-

toms: first, by involuntary motor agitations, which we studied in our last lecture in the form of choreas and of more or less extended tics; and secondly, by hysterical paralyses. I don't insist on the details of these phenomena, on the different degrees of these paralyses; it is enough to have presented to you this general conception.

LECTURE IX

THE TROUBLES OF VISION

The troubles of different perceptions, touch, smell, taste, hearing — The total dissociation of the function of vision — Hysterical blindness — The partial dissociation of vision — Unilateral amaurosis — The contradictory characters of this amaurosis — The dissociation of the monocular and the binocular vision — The narrowing of the visual field — The dissociation of the peripheric and central vision — The problem of hysterical hemianopsia compared with hysterical hemiplegy — Dyschromatopsia — The troubles of the movements of the eyes

You have just seen from our remarks on hysterical anesthesia that this neurosis may disturb the sensorial as well as the motor functions. This remark is extremely important, and the sensorial disturbances due to hysteria constitute a very considerable chapter of pathology. In this summary review of the great symptoms, we cannot follow this disease into the domain of each perception. Moreover, what will be said about a particular sense can easily enough be applied to all the others.

On what sense must we particularly insist? What are the perceptions on which hysteria determines quite typical disturbances? We have already spoken of the tactile sense. Besides, we may remark that disturbances

of the tactile sense are not quite separate, that they are nearly always connected with disturbances of motion. Remember this old remark of a French doctor to whom, in my opinion, justice has not been fully done, Dr. Burcq. "Anesthesia," he said, "never exists without amyosthenia, that is to say without muscular weakness." No doubt, in certain cases, the tactile perception may be disturbed only as perception in subjects who need their tactile sense to recognize objects, but this occurs seldom. You may also observe disturbances of tactile localization, particularly the singular phenomenon called allochiria, in which the patient always localizes on his left side what is done to him on his right side, and vice versa.[1]

Lastly, you may connect with disturbances of the tactile sense certain abnormal pains and sensations, but deliriums always enter into these phenomena, or at least associations of fixed ideas. No more do I insist on the senses of smell and taste. They are very often disturbed in hysteria, but scarcely ever so in an independent way. Their disturbances are nearly always associated with those of the functions of alimentation and breathing. We shall find them again when we study the disturbances of the visceral functions.

It would be more proper to devote a lecture to hysterical deafness, to disturbances of hearing in these patients which are often associated with disturbances of speech, but may also exist separately. Beware of hysterical deafness; it is frequent and, if I mistake

[1] With reference to this problem, see the chapter on *Un Cas d'Allochirie*, in my book "Nevroses et Idees fixes," 1898, p. 234.

not, occasions very numerous errors of diagnosis. To recognize it, with reference to these troubles of hearing, I am glad to indicate to you an interesting study of Dr. G. L. Walton: "Deafness in Hysterical Anesthesia," published in *The Brain*, 1883. To recognize this affection, remember that it is a central and not a peripheric deafness. Rinne's well-known experiment will give you information concerning this first point. When the deafness is peripheric, when it is due, for instance, to obstruction of the canal, to a disease of the ossicles, or to a disturbance in the æration of the drum, the patient keeps the central audition. You may verify it by making him hear a watch or a diapason applied to his teeth or to the bones of his skull. The vibrations propagated through the bones are still heard, whereas they can no longer be transmitted by the air. In central deafness it is just the reverse, and the hysterical disease is connected with this last group. This being once established, you will be able to make the diagnosis by studying the motile and contradictory character of this anesthesia, and by examining the evolution. I regret not being able to insist any further on this curious symptom, the study of which is now beginning to be in fashion. But there is a sense so interesting from the point of view of hysteria, and the alterations of which are so characteristic for the comprehension of this neurosis that I want to devote to it as much time as possible, and it is the reason why our study on the hysterical disturbances of the perceptions must be, above all, a study on the diseases of vision.

I

You know now the general idea that directs us in the examination of the innumerable phenomena of hysteria; it is the idea of dissociation. This disease seems to have an analytic power; it decomposes the enormous psycho-physiological system, it separates its functions. Nowhere is this dissociation more precise and curious than in the case of vision. The reason is that vision is a very complicated function, which is subdivided into numerous operations and which plays a great part in the mind. Hysteria can effect on it every possible dissociation. First, it may separate at once the whole of the visual function from the ensemble of the mind; this is the most radical and the rarest dissociation. Then it may cause the visual function to crumble, so to speak, dividing and subdividing it into its elementary functions, doing away with one and sparing another with a cleverness that the greatest physiologist might envy. You even see here an example of the services that hysteria may render to the physiologist by teaching him in what way composite functions are decomposed, which he would be unable to analyze himself.

The first great disturbance, we have just said, is the dissociation of the ensemble of vision. In other terms, it is hysterical blindness. This phenomenon is rare, for it seems that the subject always keeps as much as possible the essential functions, and loses only a part of the vision. However, the fact has been very often established. As long ago as 1618, Lepois pointed out

this blindness. Since then it has been studied by many authors, and, in this respect, I especially draw your attention to the works of the French oculists, such as Landolt, Borel, and Parinaud. This total blindness comes on usually in consequence of accidents, and it belongs to the phenomena of traumatic hysteria.

The following are the two latest cases I have observed. A man, thirty-eight years old, was busy cleaning a machine. A rag full of grease and petroleum caught in a gear and lashed him on the face. The face was only dirtied, and he did not trouble about the accident. He washed himself, but he had much difficulty in clearing his skin and eyelids of these fatty substances. Remark that nothing penetrated into his eyes and that he felt no pain in them. However, after an hour, he seemed to see as it were a mist before him; this mist grew thicker and two hours later he could no longer see at all. His vision fluctuated a little on the morrow and the following days. From time to time he could see a little, chiefly with his right eye. These fluctuations lasted for a month, then they disappeared absolutely and for four years he remained quite blind. Here is a woman, thirty-one years old, whose story is similar. In a laundry where she worked she received in the face some water mixed with soap and lime, in consequence of the explosion of a boiler. Her skin was lightly burnt and her eyelids swelled. She was in her menstrual period when the accident happened; she felt very much agitated and very giddy. During the first days she hardly dared open her eyes; it was soon noticed that she could see no more. The amaurosis was complete for

two years. When I examined this patient, there was already a slight restoration of the vision, which was easily and rapidly completed. In other cases, the blindness is less serious; it lasts a few days and disappears suddenly. A woman of twenty-seven has the following singular habit; while reading, she sees, as it were, a red flash of lightning which illuminates the room; she shuts her eyes and, when she opens them again, she sees no more. Once this accident lasted twelve days, another time seven, another eight. Her sight comes back suddenly, just as it disappears.

It is needless to tell you that, when the blindness is thus complete, the diagnosis is very difficult and that you cannot take too many precautions. Of course you must first ask for a thorough examination of the vision made by a competent oculist. You should beware of lesions of the fundus of the eye and of the optic nerve, of hemorrhages of the vitreous body, etc. Inquire into the state of the pupillary reflexes. Theoretically they must be quite normal in hysterical blindness; it is a rule we have already seen. It was so in the three cases of which I just spoke to you. It is true, you may have complications connected with the contractures of the iris, but then do not be in too great a hurry to make a diagnosis. Of course you will find a great help in the study of the mobility of the phenomenon, if you can provoke it. Sometimes this kind of blindness disappears absolutely in abnormal states, in crises or in somnambulisms; then it is all right. Lastly, you will sometimes succeed in making the contradictory character evident and in showing that, in reality, the hysterical can see,

though she maintains the contrary. Professor Jolly, of Berlin, said in this respect: "Those children, who seem not to perceive any light, nevertheless avoid obstacles unexpectedly put before them; they do not behave like people really blind, they must have a kind of perception." [1] You recognize in this our subconscious perception, the establishment of which assumes great importance here. It is however, true that complete, hysterical blindness, which happily is rare, is always very perplexing to physicians.

Happily it is no longer so, when we consider the incomplete and more frequent forms into which hysteria decomposes the visual function, doing away with only one part of it. The simplest and, if I may say so, the most amusing of these decompositions is *unilateral amaurosis*, which is simply grounded on the fact that man has two eyes and that total vision is a system composed of two visions. Very often you hear young people complaining that they see only with one eye. They do not trouble very much, however, about this accident; usually, they do not know its origin and have noticed it by chance. Being one day obliged, for some reason, to keep their right eye shut, they are quite surprised to find themselves in darkness. You repeat the experiment, and you recognize that they see quite well when they have both their eyes open, but see absolutely nothing when one of their eyes is shut. These observations are innumerable and they have given rise to many studies and discussions about hysteria. It is perhaps

[1] F. Jolly, "Ueber Hysteria bei Kindern," *Berliner Klin. Wochenschr.*, 1892, No. 34, p. 4.

one of the facts which served as introduction to the studies of experimental psychology.

The reason is that this amaurosis presented itself in rather odd conditions and was for oculists an irritating problem. Why? There is nothing extraordinary in the fact that an eye is affected separately. It is because we find here, carried to the highest degree, the character of hysterical anesthesia. First this blindness occurs without any appreciable organic disturbance and without any impairment of the elementary function of the organ. The eye is absolutely uninjured outwardly and inwardly; its important reflexes are quite unimpaired. However you may, not infrequently, recognize a suppression of the reflexes of peripheric origin; I mean the corneal and conjunctival reflexes. The touching of the conjunctiva or of the cornea with a bit of paper, for instance, will not bring on the spasmodic shutting of the eyelids. We have there a reflex of superficial sensibility which may be disturbed. But the pupillary reflexes to light and to accommodation are mostly perfect, with a reservation of contractures of the iris, of which I told you to beware. In these conditions physicians are astonished that the subject cannot see.

In certain particular cases, their distrust is still more justifiable, as when, for instance, before the board of examination for recruits, young men, wishing to avoid military service, maintain that they are blind of the right eye and that they are unable to take aim. The army surgeon charged with the inspection has certainly a right to express some doubt, when he does not recog-

nize any objective disturbance in this eye and sees the pupil react to light as if the retina perceived quite well. He invents subtle processes to find out what he thinks is a fraud. The two prettiest of those processes are the letters of Snellen and the box of Flees. On an absolutely dark ground are pasted letters cut out of paper, some blue, others red. To the eyes of the subject is applied a pair of eye-glasses, one of the glasses of which is quite of the same blue tint as the letters, and the other of the same red tint. Through the red glass, which lets only the red rays pass through, the red letters on the black ground can be seen, but the blue ones become as black as the ground and cannot be distinguished from it; while the reverse is true for the blue glass. The result is that, in these conditions, the right eye can read only one-half of the letters and the left eye the other half. A person who sees with both eyes instinctively completes one eye with the other and reads the whole word without difficulty. In these conditions, a one-eyed person can only read a part of the letters. Now what does our recruit do? With the eye-glasses on his eyes, he quietly reads all the letters on the black board.

The box of Flees is still more ingenious. Here (Figure 12) is its schema: the subject looks into a little box through two holes corresponding to his two eyes, *D* and *G*. At each end of the box are two coloured spots, two wafers, one red, *R*, and the other white, *B*, for instance. But the subject cannot see them directly, he only sees their images in two little mirrors, *MM*, hidden in the bottom of the box in black paper and making an angle of 45 degrees with the bottom. These mirrors

cast the images of the wafers sideways, in a strange way; the object, which in reality is seen by the right eye, *D*, appears on the left side in *B*, and the object, which in reality is seen by the left eye, *G*, appears on the right

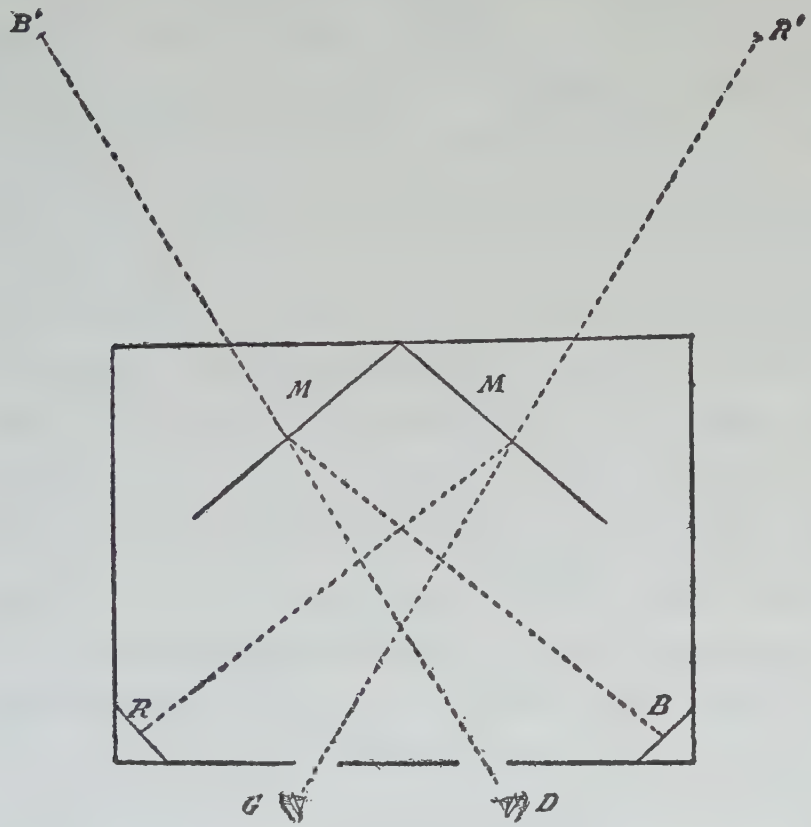


FIG. 12. — Schema of the box of Flees.

side in *R*. Neither, however, of those wafers can be seen simultaneously by the two eyes. How would a one-eyed man, who has really lost his left eye, conduct himself when asked to look into this box? He would say: "I see only one wafer, the white one, *B*, for instance, but what astonishes me is that it appears on my left side; now usually, I am not able to see on this side."

What will a malingerer do who sees with his left eye but pretends to be blind of this eye? In reality he will see the two wafers, but as he will think it necessary to suppress one, he will of course suppress the one which appears on the left side, the supposed blind side; he suppresses the white wafer, *B*, and he declares that he sees only one wafer, the red one on his right side. Now as this wafer, *R*, can only be seen by the left eye, which he pretends is blind, the fraud is discovered.

How do our hysterical patients conduct themselves in presence of this box? We must admit that they look very absurd: Oftenest they naïvely say that they see both wafers. You will understand that formerly, in these conditions, they were generally accused of fraud. It is strange to remark that our hystericals are not lucky; their accidents are such that they are nearly always mistaken for crimes or tricks. Some were burnt on account of their fits or devil's claws, others were sent to prison in order to be cured of their amaurosis.

However it may be, these singular facts discovered by army surgeons had excited curiosity: there was a time, especially in France, when the apparently insignificant little phenomenon of unilateral amaurosis was intensely studied. With the researches of that period are connected the names of Regnard, Parinaud, Bernheim, and perhaps also mine, if you will allow me to recall it. To the preceding experiments many others of much the same kind have been added. You know the old experiment of the physicist Brewster: if the subject looks at an object with both eyes open and if you press slightly on one of his eyes, he sees two objects instead of one,

simply because the object is no longer painted on the concording points of the two retinas. If, in the same conditions, without touching the eyes you put a prism before one eye, the same phenomenon takes place, the object is doubled. Of course this doubling implies the existence of two eyes and two visions; nothing of the kind takes place if the experiment is repeated with a one-eyed person. You can verify it yourself by shutting one eye and slightly pressing on the other; the object moves, but is not doubled. Well, in the unilateral amaurosis of hystericals, all these experiments and many others of the same kind give the same results as with normal subjects who see with both eyes.

The explanation based on fraud is very simple, perhaps too simple in the case of persons who are not recruits and have not the least interest in giving themselves out to be one-eyed, and must even pay the oculist when they take advice. With a more attentive observation this first interpretation of things was given up. We have all recorded our word on this question. Of course M. Bernheim spoke of suggestion. I have myself insisted on the subconscious sensations, which continue to exist in certain cases, though the subject has no personal perception of them. But now I acknowledge that M. Parinaud has given the best formula of this special fact. In a pretty disquisition on vision he showed that the existence of the two eyes and their position gave birth to two different visions. First, there is the monocular vision, either separate or alternating, which is the only one with many animals, as horses, whose eyes are on either side of the head. They can

look to the right or to the left, they can alternate, but that is all. With animals such as man, monkeys, and some dogs, whose two eyes are nearly on the same plane, things are more complicated. These beings may have not only the preceding monocular and alternating vision, but also another vision called the binocular vision. This vision consists in the synthesis of the two preceding ones, which enables us to see only one object with two eyes. This vision is an improvement on the preceding one, in that it allows us to see the same object more clearly, permits fixity, and gives the appearance of relief. It is the starting point of the experiment with the stereoscope. Generally we make use of this vision, but we retain the possibility of using the inferior vision, which we utilize in many cases, sometimes involuntarily to see sideways, or when one eye is tired, sometimes voluntarily by shutting one eye when taking aim with a pistol or looking in a microscope.

Now it is very curious to see that hystericals are able to effect the dissociation of these two visions, the existence of which we scarcely suspected. They mostly lose — and this is an accident that was not known — they lose the binocular vision, that is to say the higher, truly human vision. Only they do not complain of it; it is the medical examination that will reveal to you this unexpected thing, that an hysterical cannot look with a stereoscope and is unable to perceive the relief in Ducos de Hauron's anaglyphs. But sometimes also they lose the monocular vision of one eye while keeping the binocular vision. The preceding experiments, by appealing to the binocular vision, by making it neces-

sary, placed hystericals in conditions in which their disturbances did not appear. You see that this singular amaurosis has already dissociated the visual function in an amusing manner, setting apart now the binocular, now the monocular function.

II

Let us continue the examination of the hysterical disturbances of vision and we shall see that dissociation will still gain ground and enter into more delicate functions. The most important symptom to be known now is the famous *narrowing of the visual field* on which we ought to be able to dwell for a long time. You know that human sight, owing to the dimensions of the retina, extends over a certain surface. The extent of the surface an eye can see simultaneously, without moving, is called the visual field. No doubt all the points of this definition should be discussed. It is not quite certain, in particular, that all the points of the visual field are seen simultaneously in a single act of attention; but this definition is practically sufficient. If you measure the visual field of a normal subject with those instruments which are called campimeters and perimeters, the description of which would be too long, you obtain the following figure, which I have presented to you in this picture of the visual field of the right eye, *R*, in Figure 13. The field has the form of an irregular circle, more extended on the external and on the inferior sides, where it measures almost 90°, which means that the angles formed by the fixation point, the eye

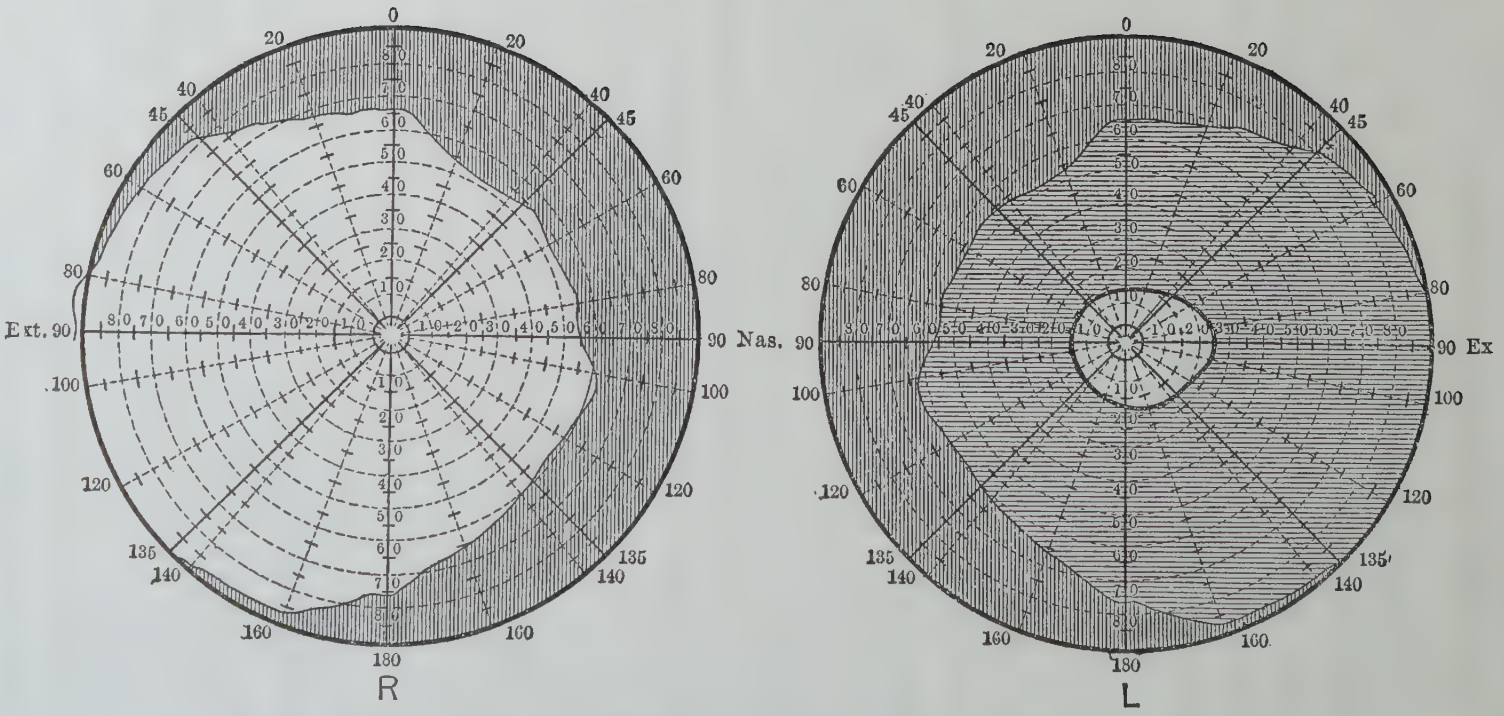


FIG. 13.—Schema of the visual field: normal in the right eye, R; narrowed in the left eye, L.

for vertex, and the limit of the visual field, is of 90°. The circle is narrowed on the internal and superior sides, where it is barely 60°; this very natural diminution is due, as you may guess, to the obstacle formed by the nose and the eyebrows.

Well, if you examine the visual field of hystericals, you will recognize a very remarkable fact, which very likely exists only in this neurosis; the visual field is narrowed concentrically. The extent of the simultaneous vision becomes smaller; the field is almost circular at 30° or 20°, as you see in the left eye of the figure 13. Sometimes the field has only 10° or 5°, and nothing is left but the fixation point. It is true that a disease of the retina, pigmentary retinitis, and perhaps also certain forms of chronic glaucoma, give rise to an analogous phenomenon, but then, in the first place, the visual field has an irregular form, and, in the second place, there are visible lesions of the fundus of the eye. As regards the diseases of the nervous system, it has been said that this concentric contraction of the visual field is found in epilepsy and in disseminated sclerosis. This has been recognized to be false; so this symptom becomes one of the most important of hysteria, not for the patient of course, but for the physician who makes use of it as a characteristic sign.

This contraction of the visual field has interesting psychological properties; it is quite a matter of indifference to the subject, and this is a curious fact, on which I have elsewhere insisted.[1] As a matter of fact nothing is

[1] "The Mental State of Hystericals," translation into English,

so inconvenient as a real contraction of the visual field; you know how the unfortunate people who are affected with chronic glaucoma complain of being no longer able to glance over their newspaper because they see only one word or one syllable at a time. These patients, who, however, see very well in the centre, can no longer find their way in the street. Hystericals, who have an exceedingly small visual field, run without in the least troubling themselves about it. This is a curious fact to which I remember having attracted the attention of Charcot, who had not remarked it, and was very much surprised at it. I showed him two of our young patients playing very cleverly at ball in the courtyard of La Salpetriere. Then, having brought them before him, I remarked to him that their visual field was reduced to a point, and I asked him whether he would be capable of playing at ball, if he had before each eye a card merely pierced with a small hole. It is one of the finest examples that can be shown of the persistence of subconscious sensations in hysteria.

Besides, I had shortly afterwards the opportunity of making a still more precise experiment on the same point. A young boy had violent crises of terror caused by a fire, and it was enough to show him a small flame for the fit to begin again. Now his visual field was reduced to 5° and he seemed to see absolutely nothing outside of it. I showed that I could provoke his fit by merely making him fix his eyes on the central point of the perimeter and then approaching a lighted match to the eightieth degree. The same experiment can be more simply realized by using suggestions, of which

we shall speak later. A subject has received the order, which he obeys unconsciously, to raise his arm as soon as he sees a paper before his eyes. The suggestion is executed even if the paper is put at the eightieth degree, far out of the limits of his conscious visual field. You see that this hysterical disturbance has not quite done away with ocular perception in the lateral parts of the retina. It is again a dissociation like the preceding ones. We have two visions, the central vision, which is accurate and attentive, and the peripheric vision, which is vacant and of secondary importance. You see that the hysterical keeps only the first consciously, the second persisting quite subconsciously.

I cannot end this examination of the visual field without saying a few words on a very curious problem in which I took a particular interest. Can the visual field be modified only in this way? In other words, is the contraction always concentric? We have not the time to examine the different faces of this problem. I shall only insist on one. Can we meet in hysteria with the hemiopical visual field or with the phenomenon of hemianopsia? The question is more important than it looks. Hemianopsia, that is to say the vision of only one-half of the visual field, is a frequent phenomenon, often succeeding cerebral lesions. The section of the optical nerves, Gratiolet's radiations, the lesions of the occipital lobes, of the cuneus, do away with the vision in one of the vertical halves of the retina, and you know that the lesion is distinguished by the place and form of this hemianopsia. After some fluctuations, physicians had come, especially after Gilles de la Tourette's

work, to deny absolutely the existence of hysterical hemianopsia, and to reserve this symptom for organic lesions. This decision is not tenable *a priori*. I do not see any reason why the functional disturbance of hysteria should not realize the same symptoms as the organic destruction of the centre of the function. Every function, as we said when treating of paralyses, finally has, when it is old, its organic centre, and, in certain cases, the functional and organic disturbances may be alike. Besides, did we not unquestionably establish this fact when we studied hemiplegy? There is no disturbance more symptomatic of a great lesion than motor hemiplegy, and nobody denies that it takes place in hysteria. It is the same with hemianopsia, and, in despite of theories, we must recognize a fact if it exists.

After the preceding period of negation, M. Dejerine in 1894 and I myself in 1895 presented the first authentic observations of functional hemianopsia.[1] I think I gave the demonstration of the hysterical character of this syndrome by showing the existence of subconscious sensations in the apparently suppressed part of the visual field (Figure 14). Since then I have had the opportunity to show other equally distinct cases, a schema of which you see here (Figure 15). In a paper which appeared in *The Brain* in 1897, W. Harris presented analogous cases:[2] he pointed out, in particular, as I had done

[1] "Un Cas d'Hemianopsie Hysterique," Lecture at the Salpetriere, on January 25, 1895, *Archives de Neurologie*, May, 1895, p. 339, and in "Nevroses et Idees fixes," I, p. 263.

[2] Wilfred Harris, "Hemianopsia with Special Reference to its Transient Variations," *The Brain*, 1897, p. 308.

myself, some cases in which hysterical hemianopsia begins with amaurosis. It is at the time of the recovery from an hysterical amaurosis that the visual field takes in many cases the hemianopsic form for some time. I refer you, with respect to this, to my paper on transitory hemianopsia.[1]

These phenomena of hemianopsia should not, I think, astonish us beyond all measure, and induce us to transform our general conception of the neurosis. The study of the anatomical localization of the vision leads us to conceive a particular distribution of vision on the retina. Suppose a man having only one eye, in the middle of his forehead, like the Cyclops, or if you prefer it, two eyes placed one under the other in the middle of his head. Each of these eyes will have a right half and a left half like the rest of the body, and a distinct function of the vision to the right and of the vision to the left will form, comprising the two right halves and the two left halves of the two eyes. Later the two eyes separated and disposed themselves otherwise, but the function has remained the same and there is still now a function of the vision to the right and another of the vision to the left. These functions may become dissociated in hysteria just as all the others; only, as these functions are very old, the dissociation seldom goes so far. It exists sometimes however, and hysterical hemianopsia is a profound accident which can be compared to motor hemiplegy.

[1] "Un Cas d'Hemianopsie Hysterique Transitoire," *La Presse Medicale*, October 25, 1899, p. 241.

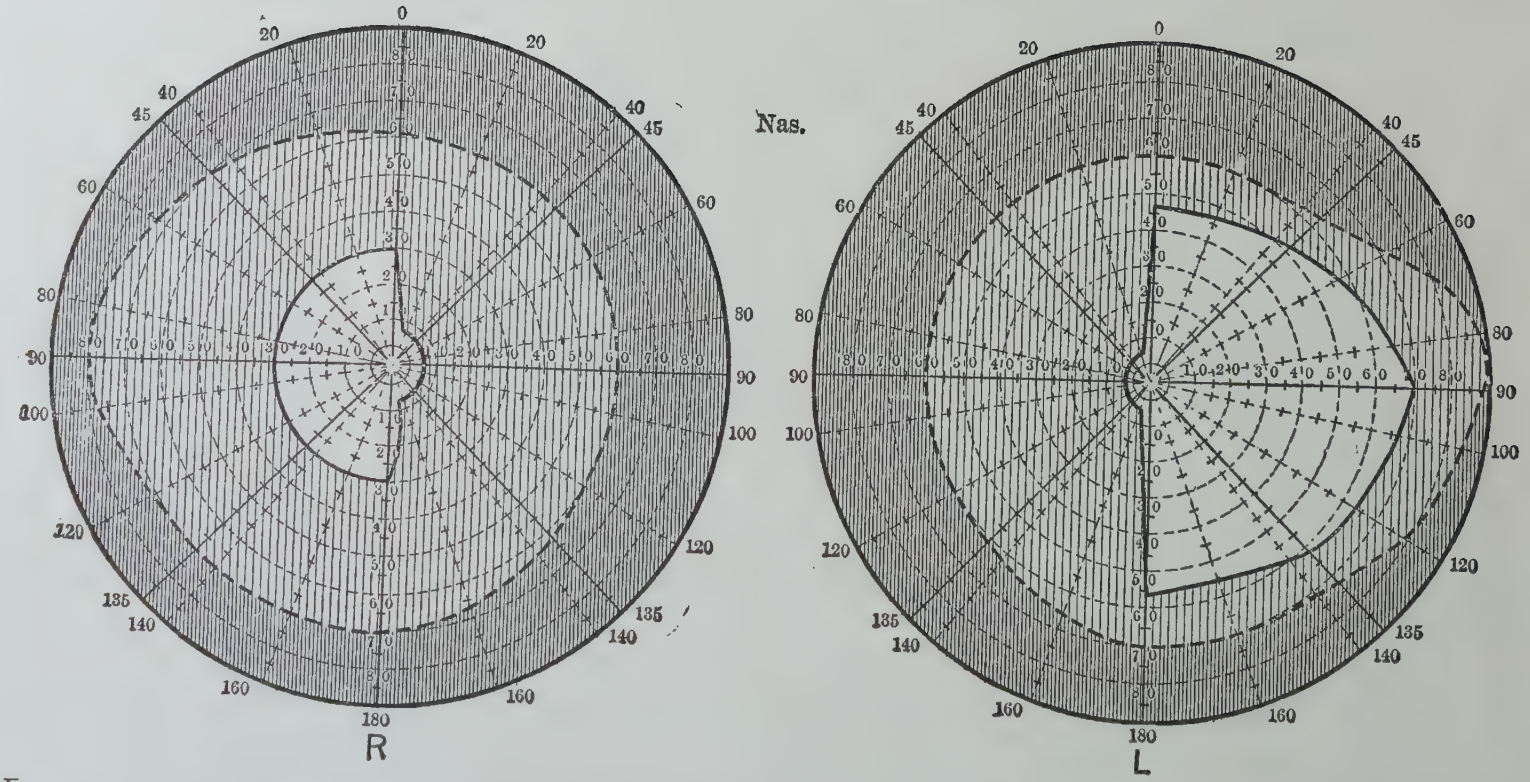


FIG. 14. — Schema of a case of hysterical hemianopsia. ——, limits of the conscious field; -----, limits of the subconscious field.

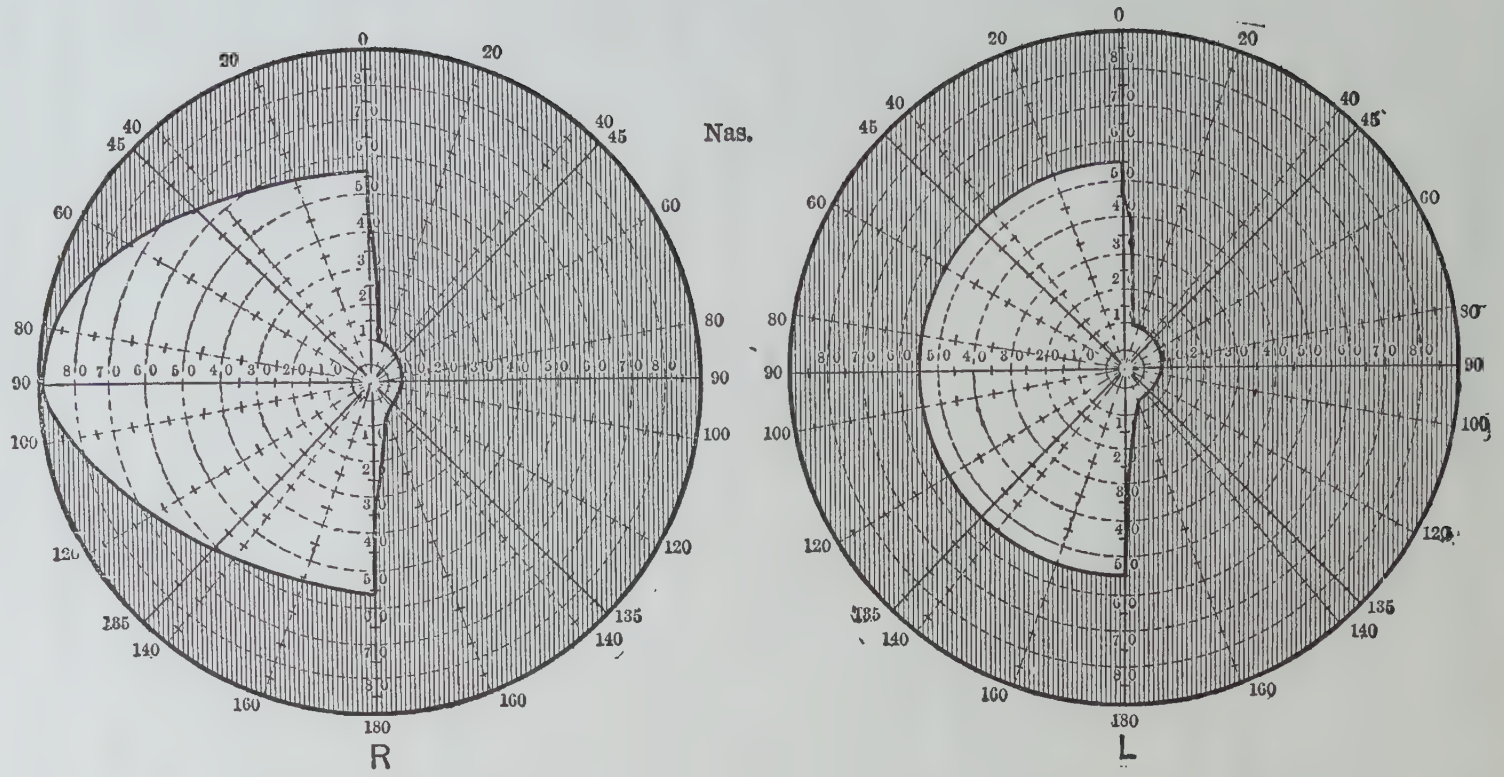


FIG. 15. — Schema of a case of hysterical hemianopsia, in the period of the recovery of a unilateral amaurosis.

III

You can now apply the same method yourselves to the interpretation of all the other visual disturbances, which are still very numerous. I will only point out to you *dyschromatopsia*, that is to say, the loss of the vision of colours. It frequently happens that hystericals, while still having a good visual acuity, cease to perceive colours, or at least certain colours. Violet, blue, and green seem to vanish first.

Red appears to be the most persistent colour. This fact was formerly considered as accounting for the fondness of hystericals for red. They are fond of dressing in showy colours, of putting red ribbons in their hair. The reason is, it was said, that these colours are the only ones they continue to see. There is some exaggeration in this, and it is more likely that moral reasons, such as the very curious need they feel to be noticed, play a more considerable part in this phenomenon.

I think also that this loss of colours has been examined with exaggerated accuracy; a visual field of colours has been drawn, and efforts have been made to prove that in hysteria this visual field is modified in a regular manner, the visual field of blue, for instance, becoming in this disease smaller than that of red. It may be so, but I advise you to be cautious in this study. First of all, the perception of colours at the periphery of the visual field changes very much, even in a normal person, according to all kinds of conditions and, in

particular, according to the lighting. Besides, in hystericals, the influence of the association of ideas plays an enormous part in the perception of colours. A young woman saw red flowers put on her father's coffin. It made her very angry, because these flowers constituted a political emblem; she now holds red in abhorrence, and has on that account a very fine perception of red and a visual field for red more extended than for white. Special account should be taken of the part played by perceptions and ideas in the dissociation of the small details of vision, particularly in the accidents of painful vision, of fears of certain colours, of *photophobia*, which I merely point out to you.

I wish to insist, before ending this lesson, on some other accidents, the types of which I must at least indicate to you. These accidents are *the disturbances in the motion of the eyes*, about which you will notice as many complications as about vision itself. Let us not speak of the movements of the eyelids; you will again find here the phenomena of paralysis, tics, contractures, which we have already studied.

But let us dwell a little on *ophthalmoplegy*, such as was pointed out by Lebreton, Ballet, Bristow, and especially by Koenig in 1891, because it is again an interesting phenomenon as regards interpretation. Certain subjects seem to become unable to move their eyes; they have an absolutely fixed look which seems strange. Such fixity of the look is often connected with an automatic fixation of certain objects or with certain hallucinations. This is the most frequent case, and when one can divert the subject from his fixed idea,

he looks in every direction. But in certain cases, which have as yet been rather seldom described, it is not so. The subject looks at nothing fixedly; he can look at different objects, but only by turning his head; it is his eyes that do not move. Earlier authors, among them Morax and Parinaud, showed that this immobility is purely in connection with the will. If the subject wants to look sideways, if he is asked to do so, if he thinks of it, he cannot manage it; but do not think it is an absolute immobility, it is sufficient to let an object fall noisily near him without warning him, and his eyes will immediately and rapidly turn in this direction. In a word, here as always, the subconscious and automatic motion is retained, whereas the voluntary motion is lost.

These disturbances of the movements of the ocular muscles may be less simple and consist in spasms, in irregular contractures. Then, of course, the eyes will deviate in one direction or the other, and you will have all possible forms of *strabismus*, the diagnosis of which is also important. Lastly the disturbance of the ocular motion may affect the internal muscles, and particularly the muscles of the crystalline lens. Here again, we have a function that becomes dissociated, that of *accommodation*. Instead of being able to accommodate their eyes to very various distances, from thirty centimeters to the horizon, these patients have only a very limited accommodation. Their eyes are an optical instrument in crystal adjusted to a given and immutable distance. When you find the exact distance to which they are accommodated, fifty centimeters for instance, or one meter, an object placed at this distance is seen

quite clearly, but it is no longer seen at all if you put it nearer or farther. This *spasm of accommodation* is connected with a great many hysterical disturbances on which I am very sorry not to be able to dwell: *monocular diplopy*, *polyopy*, *macropsia*, *micropsia*, etc. Now objects are seen double, or triple, and that by a single eye, which, from the point of view of optics, seems quite paradoxical. Now they are seen too large or too small or deformed in a thousand ways. I have described in this connection some very odd phenomena:[1] objects appearing to the subject too big or too small in one of their halves only, and quite normal in the other — a kind of hemimacropsia.

I shall only point out to you, if not two theses, at least two tendencies in the interpretation of these odd phenomena. M. Parinaud and his school sought a physical interpretation of the accidents in the contracture of the crystalline lens; others attribute a more important part to psychological phenomena. You have here a fine field open to your personal researches. You see what would be the richness of a study that bears upon the hysterical disturbances of visual perceptions.

Let us only retain the two following general notions: First, the disturbance is never very profound, and always bears solely on attentive and voluntary perceptions. It always spares the elementary sensations, reflexes, anatomical movements. Second, the disturbance seems to consist in a very curious separation of the different functions united in the vision, which all at the same time, or each in its turn, separate from personal consciousness and seem to proceed henceforward on their own account.

[1] Nevroses et Idees fixes," I, p. 276.

LECTURE X

THE TROUBLES OF SPEECH

Importance of the psychological study of the disturbances of speech — Description of some cases of hysterical mutism — The part played by emotion, by shocks on the right side — The characters of hysterical dumbness — The forgetfulness of speech — The absence of paralytic phenomena — The alleged differences between hysterical mutisms and organic aphasias — The different forms of hysterical dumbness — Aphonia — Stammering — Aphemia — Agraphia — A case of hysterical word-deafness — Automatic speech during hysterical mutism or alternating with periods of dumbness — Tics or agitations of speech — The emancipation of the function of speech

As we now know the disturbances of motion and those of perceptions, we can enter upon the study of a complex phenomenon, which, in reality, is nothing but a mixture of the preceding symptoms; I mean the disturbances of speech. The function of speech plays a considerable part in every impairment of thought; it is always more or less modified in all intellectual disturbances. However, most mental derangements bear upon a somewhat higher level, upon the formation of ideas properly so called. On the contrary, hysteria, which bears essentially upon the voluntary functions of motion, upon the conscious perceptions, reaches precisely this mental

level to which speech corresponds, and must determine very frequent disturbances in the expression of thoughts. These disturbances have long been known, but physicians have generally been inclined to consider them as being of quite a particular nature. They thought that hysterical phenomena could not be like others, and it seems to me that they separated far too much the disturbances of speech in hystericals from the pathology of speech in general. I should like to show you that all the disturbances of speech, whatever they may be, are to be found in these patients, and that you can study the pathology of aphasia in them as well as in organic patients, and even better. Now, when in the papers of Dr. Pierre Marie of Paris the troubles of aphasia are brought nearer the disturbances of thought,[1] it is interesting to study the hysterical troubles of speech in which the alteration of the whole consciousness is more evident.

I

In antiquity certain impairments of speech had already been noticed, the rapid evolution and the surprising cure of which seemed unaccountable. The following observation made by Hippocrates appears to relate to a hysterical accident: "The wife of Polemachus, having an arthritical affection, felt a sudden pain in her hip, as her menses had not come; having drunk some beet-root water, she remained voiceless for the whole night until mid-day. She could hear and understand;

[1] Pierre Marie, "La Revision de la Question de l'Aphasie," *Semaine Medicale*, 1906.

she showed with her hand that the pain was in her hip." This description seems to contain everything, the stopping of the menses, the arthritic disturbances, which are probably disturbances of motion, the preservation of the perceptions of speech, and the dumbness. It is not necessary to remind you of the story of Crœsus's son, the dumb young man who suddenly recovers his speech to cry: "Soldier, do not kill Crœsus."

We may pass on to modern times, and remind you of all the stories of dumbness in possessed people and ecstatics. I have already alluded to Carre de Montgeron's work on the "Miracles of Deacon Paris," in which you can read the case of Marguerite Françoise Duchesne. After a fit of lethargy which lasted seven or eight days, there appeared a nearly total loss of voice. She was deprived of everything, even of the power of complaining. A month afterwards, she recovered her hearing and sight, but it was not the same with her voice, which was never restored to her. In the nineteenth century, such cases become more numerous. The English surgeon Watson boasted of having, through an electric treatment, restored the power of speech to a young lady who had been voiceless and dumb for twelve years. Briquet, Kussmaul, Revillod, Charcot, and Cartaz insisted very strongly on these phenomena, which are now well-known in their ensemble.

This accident may happen to confirmed hysterics, who have already had many accidents of the neurosis, after a somnambulism or a fit, but they may also happen to people who have hitherto seemed nearly normal. It is almost always brought on by a great and somewhat

sudden emotion. It was so, for instance, in the classical case studied by Charcot. A man of about forty, living in a little town, had saved some money; his wife persuaded him to come and spend it in Paris. He settled with her in an hotel in the metropolis. One day, after a short absence, he came back to the hotel and found that his wife had disappeared, taking the little hoard with her. The poor man was so upset that he was deprived of utterance, and remained speechless for eighteen months. Now, though seemingly cured, he is still liable to the same accident; at the least emotion or fatigue, he loses again the use of speech for a fortnight or for two months. Notice by the way this character of hysteria: when an accident has once happened in a particular and serious form, it is always the same accident that reappears on every occasion.

The same remark applies to the following observation which I have noted down: A man who is now forty-six has been ill since he was twenty. One day at that period he was in a garden near a glass veranda; a heavy object thrown from one of the upper floors fell on the veranda and broke some of the glass with a noise like the report of a gun. Our man was very much frightened and remained dumb for two months. Though twenty-six years have elapsed since the accident, he never recovered from it; the slightest noise he hears suddenly near him, a word spoken somewhat too loud, is enough to make him dumb again for thirty or fifty days. In other observations, the dumbness begins in young women of twenty on occasion of a fire, of the breaking off of a betrothal, or of a quarrel with their

parents. In one case it is caused by the sudden appearance of a man disguised as a spectre; the accident happened when she was eighteen and is not yet cured at forty-one.

Sometimes the emotion bears particularly on the organs of speech or respiration: it comes on after a sore throat or a disease of the chest. In certain cases, one must not forget that the accidents bore on the right side of the body. A young man of eighteen fell from horseback on his right knee; the consequence was a really hysterical hemiplegy of his right side and dumbness. A young woman working in a tavern hurt her right hand with a broken bottle. She was first paralyzed in her right side, and this paralysis seemed to extend to the throat, for she lost the use of speech. These last cases are important in regard to the association of paralyses of the right side with aphasias. In another curious case I will remind you of the story of a woman, a great spiritualistic medium, who, after having too often made use of automatic writing, was affected with hysterical dumbness. This again is interesting as regards the interpretation.

However it may be, when this dumbness is constituted, it appears nearly always in the same manner of which Charcot gave a very famous and vivid picture. The patient, save in exceptional cases, looks healthy and is not paralyzed. He has not that weak and sickly appearance of persons struck with an organic hemiplegy consequent on a cerebral hemorrhage. Nor does he offer a very visible intellectual weakness, the dazed look of the latter patients; on the contrary, he seems intel-

ligent and lively. He comes forward with an expressive face, understands all you tell him, but takes a singular attitude when he has to answer. The characteristic fact is that he does not try to answer; he does not make those efforts of speech that an aphasic person makes, or that a foreigner makes when trying to express himself in a language he knows imperfectly. He does not look as if he thought it possible to answer with words; he does not open his mouth; he makes no sound; he answers with signs, or else takes up a pencil and answers in writing. In a word, there is no imperfect speech, there is no speech at all, and there does not even seem to be any idea or remembrance or wish of speech. The subject seems to have forgotten that use which men, right or wrong, have made of their mouths. I insist on this character, because all the authors, with much exaggeration in my opinion, make it a sign of distinction between organic aphasia and hysterical dumbness.

When you try to realize the reason of this silence, which has often lasted for months together, you examine the different peripheric organs and then notice the second character of our affection; namely, the total absence of paralytic phenomena. The lips, cheeks, tongue, and soft palate move easily in the most correct way. The patient, who understands everything, does all he is asked, moves his lips, bares his teeth, smiles, draws his lips one way or the other, makes all the movements of his tongue, and that without difficulty. No doubt I think, in certain cases, some reservation should be made about this somewhat too theoretical description of

Charcot's; you will very often find in these mutes certain small localized disturbances of such or such an organ, for instance slight contractures of some muscle of the tongue. You must seek for them carefully, for it is important to do away with them before trying to bring back speech. You will also remark that the movements of the lips are not so perfect as Charcot said: there is no paralysis, properly so called, but there is often awkwardness, clumsiness, and ugliness. Yes, ugliness; these subjects, whose mind retrogrades, in my opinion, lose the delicacy, the perfection, of certain functions, and you can very well notice their return to animality from the vulgarity of certain delicate movements. However, I readily recognize that these motor impairments are slight, and quite inadequate to account for the enormous paralyses of speech which are to be observed.

If we go farther, we try to study the condition of the vocal chords. This study, begun in Charcot's time, is summarized in the thesis of Cartaz. He recognizes that, in reality, there is no great disturbance in the vocal chords. Certain authors have tried to establish a certain degree of paresis in the adduction, but I fear they have deluded themselves. The only means we know to establish the drawing nearer of the vocal chords is to ask the subject to speak or utter a sound. Now, as he cannot speak or cry, he does not produce this movement before us. There is nothing to prove that the vocal chords are not able to accomplish it, if it were asked of them. So we are again obliged to appeal to moral phenomena in order to explain the

hysterical syndrome, and all the authors are obliged to acknowledge that the disturbance is purely mental.

II

One of the things that, in my opinion, obscured this study at the outset and brought on many difficulties is the difference that physicians at once wished to establish between these hysterical mutisms and the aphasias accompanied with right-sided paralyses which were observed to succeed hemorrhages and softenings of the brain, and whose cerebral localizations were so eagerly studied in imitation of Broca. Aphasias with destruction of the third frontal convolution were, it was said, the true impairments of the psycho-physiological function of speech; and these aphasias do not present the same symptoms as hysterical dumbness.

In aphasias, the subject feels that he has lost the use of speech, and he makes desperate efforts to express himself. These efforts have some success, for he has never lost all power to utter a sound; he can give cries, make varied noises with his larynx; oftenest he has even retained a few words, which have more or less meaning, as "papa, come, come . . . macassi; macassa . . ." which he repeats at random, sometimes oddly varying the intonation.

On the other hand, the disturbance spreads farther; a patient who cannot speak at all very seldom keeps all the other functions of speech intact. He has nearly always considerable disturbances of writing; he can no more read, or he reads with difficulty, without

understanding the meaning of what he spells; lastly, he does not thoroughly understand the words spoken before him. These different disturbances, which nearly always exist in germ in aphasia properly so called, may develop separately. You know the classification of the disturbances of speech made in this connection according to the predominance of such or such a symptom: motor aphasias, agraphias, sensorial aphasias with word-blindness and word-deafness have been described. Nothing of the kind, it has been said, is to be found in hysterical dumbness, which seems to be at once more extended and more restricted. It is more extended, for in this case, motor speech is more distinctly done away with, and the subject does not seem even to make efforts to speak, as aphasia patients do. It is more restricted, for the disease seems to be limited to the expression of words and not to impair kindred phenomena, such as writing, reading, and the understanding of words perceived by the ear. So the two things are different, and as aphasia was considered as the impairment of the function and of the centre of speech, hysterical dumbness was necessarily quite another thing.

To these remarks, which I think quite wrong, we must first answer clinically. Hysterical dumbness, which I have described to you after Charcot, is a type, this word being taken in the sense given to it by this author. It is a particular and striking case, which is very remarkable from many points of view, but was somewhat arbitrarily chosen. You must not fancy that all the disturbances of speech brought on by hysteria are always conformable to this theoretical model.

We have first to put beside it many attenuated, imperfect, or rather incomplete forms, in which the function of language is analyzed as the visual function was before. One of the most frequent forms distinguishes the two degrees of vocal power we have at our disposal. We have the loud voice with intense sounds, which enables us to be heard in public, and we have the whispering voice, in which the movement of the lips and tongue is complete, but in which there is very little emission of air. Very often in hysteria, the first voice is lost and the second is kept; it is what is called *aphonia*. In certain cases, the dissociation is still nicer; certain subjects can sing aloud and cannot speak except in whispers. These distinctions will remind you of astasia-abasia. In still other cases, there are only slighter disturbances of speech: the subject can speak, but *stammers*, or stutters, or has a special voice more or less different from his normal voice. I do not insist on these varieties, because it is more important to study the varieties approaching the table of aphasia properly so called.

In my opinion, many hystericals have disturbances of speech quite identical with those described as succeeding an apoplectic ictus. Here is an observation I borrow from the second volume of my "Nevroses et Idees fixes," page 452. A young woman of twenty, in consequence of various emotions, shows for a few hours or days a very singular disturbance of speech, that little resembles typical hysterical dumbness. First of all, she is not voiceless, and can make a noise with her larynx; she even utters cries, either spontaneously

or when she is asked. Nor is she quite dumb, for she tries to speak, which the preceding patients did not do. She makes with her tongue and lips movements that produce articulate sounds; but these sounds have no meaning, and they nearly always consist in the repetition of a few incomprehensible syllables. If I say to her: "Miss X., you walk much better to-day," she answers, smiling: "petitbedable, petitbedable, chacha petitbedable." — To the question: "What happened to you to-day?" she replies very quickly: "Petitbedable, chapetit, petitbedable." We can draw nothing more from her; she will go on with this "jargonnage," as she says, for a few hours. Notice that we have here a real oblivion of the movements necessary for the pronunciation of words. She is impatient at not being understood, and seeks to answer by giving different intonations to her word "petitbedable." It seemed to us that the intonations were often right, as well as the expressions of the face, but the words never changed.

Are other functions of speech disturbed? The audition of words is not disturbed in the least, she can understand very correctly all that is said to her. She reads very well; I mean that she does all you ask her in writing, but she is unable to read aloud. As for writing, it is not totally lost, but there is a phenomenon that appears to us worthy of remark. The writing has quite changed; it has become very bad; it is curious to compare her writing during this state with her normal writing. You see that the faculty of writing is markedly diminished, if not entirely lost. How can we designate these symptoms, if not by the usual words

of motor aphasia or aphemia with a certain degree of agraphia?

It is needless to demonstrate here that these symptoms are hysterical: with such a patient, the demonstration would be superfluous. Besides, these phenomena will disappear in a few hours; we could, if we chose, cause them to disappear immediately. During the hypnotic sleep, which is easily induced, the patient will at once assume a normal manner of speaking. What is more, as we shall see presently, the subject presents, even during her periods of disturbance, automatic words, which she utters during a state of delirium, and which are quite normal. It is then an altogether hysterical phenomenon, and yet, as you see, it differs in no way from an organic aphasia. Such cases might easily be multiplied.

Besides these cases, you can observe as many phenomena of agraphia as you please. I have already indicated to you the loss of writing as one of the possible forms of systematic paralysis. Charcot already pointed out some such cases in his "Leçons du Mardi,"[1] Lepine, Ballet, Sollier published some, I observed several. You may even observe some curious forms, in which the writing becomes again childish and is quite like old writing books of the patient.

Can we go further? Do there exist in hysteria *word-blindness* and *word-deafness?* For my part, I am convinced of it, and I do not see why this dissociation should not take place when all the others do. It must be acknowledged, however, that cases of this kind

[1] T. M. Charcot, "Leçons du Mardi," p. 367.

have seldom been published. I therefore recommend to you to study an observation that in my opinion is important, the one which concerns a young girl called Rachel, and which I published in the second volume of my book on "Neuroses and Fixed Ideas." [1] The observation and the discussion are too long to reproduce here. I only point out the principal points. A girl of nineteen has a strange bearing. As soon as we speak to her, she looks embarrassed; she does not answer, moves on her chair, moans, and at last says: "I do not understand, I cannot understand." At first sight it looks as if she were deaf; that is, moreover, the dominant opinion entertained about her in her surroundings. Yet this opinion is not right. If you make a noise behind her, she almost always turns round. Curiously enough, if you put a watch near her ear, she declares that she hears; you may thus recognize that she hears the ticking of the watch at sixty centimetres on the right and at forty on the left. The hearing of this girl was very carefully examined by M. Gelle two different times. His conclusions were always the same and quite definite; this patient is not deaf by any means; all we can say is that there is a slight diminution of the auditory acuity, especially on the left. There is no appreciable lesion of the external auditory apparatus.

But then why does not this patient answer us? Because, as she says herself, she does not understand. Though she hears our words, they have no meaning for her. It is the same with musical airs. She hears them very well, but she does not recognize, does not

[1] "Nevroses et Idees fixes," 1898, II, p. 456, Observation 134.

understand them. In a word, it is the syndrome well known under the name of word-deafness. In the present case, this word-deafness is quite complete. The patient has also completely lost the functions that appear to depend on word audition. She is quite incapable of writing from dictation, and of repeating, even without understanding them, the words spoken before her. They are noises, she says, and she does not know how she could manage to repeat them. The disappearance of that connection between sounds and movements has often been noticed in word-deafness. If the word-deafness is complete, it is none the less very isolated, that is to say, all the functions of speech save the audition of words seem to have remained quite intact.

Now what are the diagnosis and origin of this clinically incontestable word deafness? They are most strange. A few years ago, this already impressionable and nervous girl was being educated in a convent. At the age of twelve, she had a typhoid fever, and remained weak and nervous, though still intelligent and free from any disturbance of speech or hearing. A short time afterwards, she began to present odd symptoms, about which, unfortunately, we have quite insufficient information, for they were only observed by the nuns of the convent. The child had a disposition to fall asleep in the middle of the day, especially between one and four in the afternoon. These sleeps were sometimes complete and very deep, nor could anything awaken the sleeper, who did not even feel prickings made in her arm. On other days, the sleep seemed

less profound, since the child kept her eyes open and went on with her sewing. But she did not answer, could not be disturbed, and, on awaking, would say that she had done nothing and was surprised to see her work getting on. This is all we know about those sleeps, which lasted for nearly two years with the same characteristics. One day the nuns became incensed at these continual sleeps and punished the child, but it was of no use. The chaplain was sent for, and it was demonstrated to her, in a fine exhortation, that if she slept again, she should first be shut up in a dark room and later on, go to hell. The little girl was frightened and swore that she would sleep no more. When the hour of her usual sleep came, she contrived, through desperate efforts, to remain awake. It is impossible for us to know exactly what happened. Rachel asserts she had no convulsions, went on with her sewing, but felt her mind confused and her head, as it were, clogged. Moreover, her recollection in this respect is very vague.

However it may be, after a few hours' discomfort, she realized that she was no longer sleepy at all. When she was spoken to, she did not answer, and her features assumed a dazed expression; every endeavour was used to rouse her, but it was soon noticed that she understood nothing and answered very badly. What was exactly the extent of the disturbance at the outset? Our information is insufficient; it seems certain that there was no paralysis, but it seems that speech was disturbed as well as hearing. However it may be, the disturbance of speech did not persist. After a few weeks, she spoke

correctly, as now; she had only a somewhat odd accent; but the hearing of words made no progress. She remained, as at the outset, incapable of understanding anything.

No doubt, all this is not very definite, and we may wish to find, later on, more distinct observations of hysterical word-blindness and word-deafness. However, these sleeps, these somnambulisms, the neuropathic disturbances which still persist, the total absence of any symptom of cerebral lesion or lesion of the ear, seem to prove that the disease approaches the great neurosis.

These observations, which could easily be multiplied, show you distinctly enough, I think, that, besides the classical and typical hysterical dumbness, there are all kinds of forms of this affection, and that some of these forms are quite identical with what is understood under the name of aphasia. So there is no opposition between those two groups of symptoms; the hysterical dumbness of Charcot is nothing but a more sharply differentiated, more isolated form of the disturbances of speech. The subject loses absolutely the power of speaking, and loses only that. He loses that power so entirely that he forgets it and does not regret it, so that he has no longer even the idea of the efforts to be made. This we already saw when studying hysterical paralyses and anesthesias. It is, therefore, very likely that the function of speech is also disturbed in the same manner in all those organic and neuropathic accidents.

III

To understand the impairment of this function of speech, we must rapidly make some remarks which you already know. Let us take up again the observation of the hysterical who to all the questions put to her could only reply with the words: "chacha petitbedable." Often, in the midst of this state of aphasia, the patient had kinds of reveries or deliriums, in which she expressed aloud, either fixed ideas which preoccupied her, or conversations she had just had, in which she put the questions and made the answers herself. In all those slight deliriums, she spoke very correctly, either in French or in English, and there was no trace of aphasia left. Observe that, in all those chatterings, she said things she regretted later on, expressing her secrets aloud. They were quite involuntary words. If you interrupted her, if you attracted her attention to ask her to reply to a question you put her, she listened, tried to speak, and no longer said anything but "petitbedable." In a word, there was aphasia in conscious and voluntary speech, and the normal expression of ideas reappeared only in the deliriums and automatic speech.

This fact is more general than is commonly believed. In patients affected with dumbness you may often recognize, in the period of dumbness itself, that normal speech reappears during the crises, the somnambulisms, the dreams. Oppenheim indicated some facts of this kind, Gilles de la Tourette describes a dumb patient who speaks during her dreams.

More often still those automatic and irrepressible words do not coincide exactly with the period of dumbness, but present themselves in the same patients before or after this period. We then find in these subjects crises of irresistible chattering, to which we already alluded in connection with somnambulisms. Sometimes these crises come on during a sleep or an abnormal state, but often they take place while the patient is awake, and then he listens in astonishment to the words he speaks. Read again, in the history of the Camisards in the seventeenth century, the anecdotes relating to the lesser prophets of the Cevennes, and to the most celebrated among them all, Elie Marion. He felt himself, as it were, seized by the Lord, he could no longer dispose of his voice, or speak voluntarily, he did not know what his mouth was about to utter, and was quite surprised at hearing the fine discourses with which the Holy Ghost inspired him. This verbal automatism should be placed beside the automatism of writing in the spiritualistic medium. He also feels that his hand escapes his control and is no longer ruled by his will; he is quite surprised at seeing what his hand has written. It is a phenomenon of the same kind.

With the same group are also to be connected the tics of speech, which are numberless in the form of coprolalia, echolalia, etc. You will find a very good description of them in the little book of M. Seglas on the disturbances of speech. I should be inclined to go even further and to say that many verbal hallucinations of inner words are phenomena of the same kind, though somewhat less marked. In all these facts, the function

of speech, which is by no means destroyed, seems to escape the conscious will of the subject. Inwardly or outwardly, he speaks in spite of himself and without any participation of his self: it is a mechanism which has emancipated itself.

Well I believe that for this fact as for the preceding ones, this symptom of agitation, of automatic functioning of the function, should be placed beside the paralysis bearing on the same function. They are two parallel and concomitant phenomena. One more example occurs to me. Bes. had very varied crises in the hospital. After her ordinary crises, in which she had cried to exhaustion, she retained perfectly the power of speaking. But she had special crises in which her speech seemed, as it were, to be thrown out of gear, in which she chattered in a low voice with extreme volubility. After these crises she always awoke dumb; the emancipation of speech brought on dumbness. This we have already seen in the somnambulism that brings about amnesia, in chorea and in the tic that brings about paralysis.

Here again everything happens as if the system of the movements and images that constitute speech separated from the personality and functioned apart in an automatic, and at the same time inferior, and, as it were, degraded, manner.

LECTURE XI

THE DISTURBANCES OF ALIMENTATION

Visceral troubles — Hysterical anorexy — The description of its three periods: the gastric period, the moral period, the period of inanition — The frequent termination by death — The theory of the fixed idea — The diagnosis with the psychasthenic refusal of food — The theory of anorexy through the anesthesia of the stomach — The part played by anesthesia in the modifications of the feeling of hunger — The motor agitation of the patient — The different explanations of this fondness for physical exercises — The suppression of the feeling of fatigue and the motor excitation — The psychological function of alimentation — The hysterical dissociation of this function — The dissociation of the elements of this function — The paralyses of the lips, tongue, pharynx, œsophagus, abdomen — The troubles of the function of the bladder

After passing in review the mental disturbances of hystericals, their sensory and motor disturbances, we shall now enter upon a rapid survey of their *visceral disturbances*. These patients, in fact, seem to present great impairments of the visceral functions, especially of the functions of digestion and respiration. These visceral phenomena have always greatly puzzled physicians, and nowadays they are still often opposed to those who want to give a mental explanation of this disease. We must, therefore, insist on their interpreta-

tion. To penetrate into the study of the mental disturbances of hysteria, we shall begin by studying a very important phenomenon, that of *anorexy*, which by its character, at once physiological and mental, will furnish a transition between these new studies and the preceding ones.

I

The words "hysterical anorexy" designate a disease both mental and physiological, very long and very complicated, which consists chiefly in the systematic refusal of food, in certain digestive disturbances, and in a consequent inanition. This odd phenomenon was for a long time very ill known; it was confusedly ranged among the other manias of those patients, and their strange way of living without eating was often ascribed to the action of the demon or to that of God.

Its accurate description is recent; it was made almost simultaneously by W. Gull, in 1868, and by Lasegue in 1873. The article of Lasegue was the only one that had success and contributed to spread this new medical notion; it led Gull to observe in 1873 that he had already indicated these facts in 1868. The English physician called this disease "apepsia hysterica"; Lasegue named it "hysterical anorexy." Neither of these two appellations is perfect; the absence of pepsine, which, moreover, is doubtful, has nothing interesting in it here; the loss of appetite is more important, but it is not certain that it is the essential characteristic. Therefore, some subsequent authors, wishing to emphasize the capital fact, which is the systematic refusal of food,

made use of the words "sitiophobia," that is to say, aversion to food, and "sitieirgia" (σιτιον ειργω), food repelling, that is to say, rejection of food; or even of the words "hysterical inanition" which Lasegue had also proposed. The last words are evidently better, but usage, which is a great master, has not accepted them and has even employed them differently. It has retained the term *hysterical anorexy*. It is enough if we understand one another.

This accident may happen in the course of hysteria after many characteristic phenomena, which will serve for its recognition. Oftenest it forms the outset of hysteria and its real nature is only recognized late. Many cases have been cited in adult and young men, but it cannot be denied that it is infinitely more frequent in women. A case has been cited at the age of eleven (Kissel); I have observed one in a little girl of nine; it has also been recognized in a woman of thirty-eight. Lately I studied a very distinct case in a woman of forty, but it was an old accident which reappeared. It must be acknowledged that these ages are quite exceptional; the greatest number of cases by far — nine out of ten — are to be met with in girls of sixteen to twenty-three or twenty-five at most. It is one of the facts of the special pathology of the girl of eighteen. You should never forget it when in presence of a patient of this age.

That affection which seizes the girl of eighteen is a chronic one. It is a disease that never lasts less than eighteen months to two years, and often continues for ten years. The result is that it goes through different periods

which Lasegue reduced, rightly enough, to three principal ones.

The first period might be called *the gastric period*, for everybody fancies that the disease consists simply in an affection of the stomach, and behaves accordingly. The beginning, which it is not always easy to know, often coincides with a slight, more or less real, affection of the stomach. More often it is again the consequence of an emotion. Mu., for instance, a girl of nineteen, of whom I often think when speaking to you of anorexy, presented her first gastric disturbances after the death of her brother, who succumbed rapidly to pulmonary phthisis. The patients complain of various and vague sufferings, which they connect with their digestion. Then come consultations on consultations and, of course, a lot of absurd diagnoses and ridiculous medicines. It is thought quite natural that the girl, whose stomach is diseased, should be careful of what she eats; her medical attendants would even be inclined to prescribe to her a still stricter diet. She resigns herself to everything and shows herself a patient of exemplary docility; moreover, save for vaguer and vaguer pains in her stomach, she seems to enjoy perfect health; her tongue is clean, her stomach and abdomen normal; the only thing she may suffer from is obstinate constipation.

Usually, after a long time, begins the second period, *the moral period*, or period of struggling. The family at length become disquieted at the indefinite prolongation of these treatments and ultra strict diets, which do not seem very well justified. They suspect hypochondriac ideas and obstinacy, and their attitude be-

comes quite modified. Now they try to allure the patient by all possible delicacies of the table, they scold her severely, they alternately spoil, beseech, threaten her. The excess of the insistence causes an exaggeration of the resistance; the girl seems to understand that the least concession on her part would cause her to pass from the condition of a patient to that of a capricious child, and to this she will never consent.

All the relatives and friends interfere by turns to try what their authority and influence may do. Lasegue has well described those distressed families who, all day and to the first comer, speak mournfully of the girl's food. It's all of no use, the disease develops more and more under the influence of these surroundings. Now the girl scarcely ever speaks of her pains in the stomach, but she repeats that she will eat when she is hungry and that she is never hungry, that she does not need more food, that she can very well live indefinitely in that way, that, moreover, she has never felt better. In fact she seems to be in very good health and shows much strength and activity. She has even a greatly exaggerated physical and moral activity, to which we shall have to revert, for the fact is very important. Supported by this conviction, our strange patient struggles with all those around her, by every possible means. She seeks a support in one of her parents against the other, she promises to do wonders if her family is not too exacting, she has recourse to every artifice and to every untruth. It is the period when such patients hide victuals in their pockets, fill their cheeks and throat with them, to go and spit them out in the

lavatory, when they learn to vomit immediately what they have just swallowed, etc.

Lastly comes on, sooner or later, but sometimes only after years, the third period, called *period of inanition.* Organic disturbances begin to appear, the breath is foul, the stomach and abdomen are retracted, there is an insuperable constipation, the urine is scarce and contains little urea — only 3 grammes instead of 30 grammes with one of my patients. The skin becomes dry, pulverulent, and in certain places, as on the wrists and forehead, cracked and covered with pimples. The pulse becomes very quick, between one hundred and one hundred and twenty, the breathing is short and hurried, you hear cardiac and arterial breaths. Lastly, the extenuation, which the parents best observe, makes surprising progress. It is a clinical fact which one must well remember, that weight is not a reliable sign of the progress of the disease; for, after a rather great decrease at the outset, it is only at the end, and often too late, that it falls suddenly.

Matters have changed, then. The patients who no longer leave their beds remain in a semi-delirious, semi-comatose condition. At this stage they behave in two different ways; some continue to be delirious, and, as Charcot said, have but one idea left; namely, to refuse to eat. Others, fortunately, begin to be frightened. That was what Lasegue expected; because of a singular therapeutic dignity, he judged that the physician was not justified in doing anything before. At that moment he resumed his authority, and according as the patient yielded completely or partially — which

latter case was the more frequent — he cured her more or less completely. In fact, the hysterical is privileged in this respect. You know that the dog cannot be called back to life when it has lost forty per cent. of its weight; the hysterical can still be saved at fifty and above. There is a limit, however. Out of his eight cases, Lasegue had not one death; the number of deaths since then cannot be numbered. I know three, for my part. It is the melancholy period when those poor girls ask to eat and it is too late. It is true that things generally take another turn, and an intercurrent disease comes on, broncho-pneumonia or almost phthisis, which simplifies the situation.

Such is the general history of this strange mental disease. Its gravity, its frequency, the regularity of its evolution, whatever may be the intelligence of the subject, show that it is due to a deep psychological disturbance, of which the refusal of food is but the outer expression.

II

This disturbance of thought is fairly well known in its details and evolution, but it is certainly very difficult to interpret, and various theories of anorexy give the preeminence to one or the other of the essential phenomena.

Lasegue, and later on Charcot, gave the preeminence to a delirious disturbance, to a fixed idea. The disease consists essentially in an idea of which the patient is perfectly conscious, though she often conceals it, and which has for consequence the voluntary and calculated

refusal of food. Some are over anxious about their stomach, apprehend the pains provoked by digestion, or simply fear the sensation of a ball in their œsophagus. Others have scruples, regret to eat the flesh of living animals, are ashamed to eat when too many poor people have not sufficient food. I knew a girl of eighteen who died in consequence of her abhorrence of turnips, which she had contracted when at school. To the end she refused to eat anything, saying that everything smelt of turnips. Very often, they simply have the commonplace idea of suicide: for some reason or other these girls make up their minds to die because of a thwarted marriage, a reproach, for having quarrelled with a friend, etc. And, in their innocence, they adopt starvation for their mode of death, judging it to be a simple, clean, not very painful process, which will arouse nobody's suspicion. The following observation of Charcot is famous: while undressing a patient of this kind, he found that she wore on her skin, fastened very tight around her waist, a rose-coloured ribbon. He obtained the following confidence; the ribbon was a measure which the waist was not to exceed. "I prefer dying of hunger to becoming big as mamma." Coquetries of this kind are very frequent; one of my patients refused to eat for fear that, during her digestion, her face should grow red and appear less pleasant in the eyes of a professor whose lectures she attended after her meals.

The authors who have observed such ideas seem to me to be inclined to exaggerate their importance. This is what certainly happened to Charcot, who used

to seek everywhere for his rose-coloured ribbon and the idea of obesity. I believe there is on this point a diagnosis to be made, on which I have much insisted in the first volume of my work on obsessions. Refusals of food are not always a phenomenon of the hysterical neurosis; they belong at least as often to the psychasthenic neurosis. It is in the latter neurosis that fixed ideas remain alone and play a predominant role to the end.

These patients will be recognized by the absence of other psychological disturbances associated with the fixed idea. In particular, they have no real anorexy; they have retained the feeling of hunger; and they often submit to veritable tortures in order not to yield to their need of food. These patients make it a point of honour not to yield, at least before others, and this accounts for an odd fact often indicated in their history. After having all day refused the food offered to them, they get up at night secretly and steal dirty victuals, so that one must always be careful to leave food within their reach. As they have no real loss of the feeling of hunger, so they have no real anesthesia, either in their mouth or in their epigastrium; lastly, they do not present that excessive need of movement, the importance of which I have already indicated in real hysterical anorexies. In the latter, in fact, the fixed idea, which existed at the outset, it is true, and played a certain role for a while, becomes complicated with very serious phenomena, as the loss of appetite, the anesthesia of various organs, certain phenomena of systematic paralysis of the acts relating to alimentation, and

the great motor agitation. I believe therefore that one should distinguish real hysterical anorexy from those refusals to eat brought on by various obsessions, and in particular, by obsessions of scruples in various psychasthenics.

Therefore, other theories tried to take these new phenomena into account, and this is done in particular by a theory which is nowadays pretty widespread, the theory of anorexy through the anesthesia of the stomach. Besides the anorexies due to delirious ideas relating to illness, to pudicity, to obesity, it has been asked whether there do not exist anorexies brought about by disturbances of the organic sensibility. They would then justify their name and be above all losses of the sensation of hunger. This already old thesis, which was indicated by magnetizers, such as Despine in 1840, has been chiefly developed through studies on metallotherapy carried on especially by Burcq, 1875–1882. Since then, it has been systematized and exaggerated by Sollier. "Anesthesia," Burcq once said, "exercises a preponderant influence on all the other symptoms, in particular on the disturbances of alimentation and on the secretions." His great argument was that he could cause these anesthesias to vanish through the use of the metallic plates and armatures he had contrived, and that he then saw the hysterical phenomena, anorexy in particular, disappear.

There is much truth in these remarks. First of all, we must recognize in anorexy, when already well settled, and of decidedly hysterical nature, the existence of numerous anesthesias. They are observed

in the mouth, on the tongue, on the internal face of the cheeks, in the œsophagus. At the same time may be noted the absolute anesthesia of the special senses of taste and smell. You know that the patients, especially at the outset of their disease, want to have raw aliments, and ask for salt and vinegar in order to give some taste to their food; and that, later on, they complain that they are given sand or earth to eat. You also know that some of them do not feel the food in their mouths. It is not rare to observe at the same time the anesthesia of the lower part of the digestive tube, of the anus, and of the rectum. The anesthesia of the stomach itself and of the small intestine is the more difficult to establish, as the sensibility of these organs is commonly very obtuse, but it is highly probable. Many subjects do not feel too hot or too cold food descend into their stomachs. Moreover, you have already seen a very curious law, indicated by M. Gilles de la Tourette, namely, that often, in hysteria, superficial anesthesia of the skin accompanies the anesthesia of the organs placed under it. Now, in hysterical anesthesia, a patch of cutaneous insensibility is often recognized, seated just in the epigastric region. It is probable, therefore, that the mucous membrane of the stomach is as anesthetic as that of the mouth.

Do these various anesthesias, seated in all the parts of the digestive tube, play a role in the disturbances of the functions of alimentation? The thing seems to me very likely. The fine studies of physiologists, in particular those of M. Pawlof, have shown that the saliva secreted by a dog varies with the object presented

to him, with the taste and smell of that object. They have shown that the secretions of the stomach and of the intestine were in connection with the sensation of the food in the various parts of the digestive tube. Since these patients feel neither taste, nor smell, nor any excitation of the mucous membrane of their stomachs, it is very likely that their digestion will be disturbed. A physician even tried to go still further. You know that the anesthesias of hystericals are mobile, that it is possible, through various processes, to cause them to disappear and to reappear. This physician thought he recognized, at least in one case, that the secretion of the gastric juice was very different, according as the subject felt or did not feel in his œsophagus and in his stomach.

From these remarks results a new conception of the disease. It is the gastric anesthesia which is here the great culprit. While the sensation of the movements and of the secretions of the stomach is the starting point of the feeling of appetite, the immobility and insensibility of the stomach bring on complete anorexy and all the delirious ideas, which are considered here as secondary.

There is some truth in this conception, but it does not seem to me to be complete. First of all, the anesthesia of hystericals is never complete, and does not do away with the reflexes. We have already studied this point. If food is introduced by force with the sound into the stomach of the most anorexic hysterical, if you prevent immediate vomiting, you will recognize that the digestion, perhaps somewhat slow at the beginning, comes to be completely effected and in the most normal

way. This M. Henry Français has just shown again in his thesis on "Apepsy," which he maintained this year. So psychic insensibility does not play here a considerable material part. Supposing the anesthesia of the stomach should do away with appetite, it would not make the patients incapable either of eating or of digesting.

In my opinion, an exaggerated importance is ascribed to the role played by these local phenomena of the mouth and stomach in the general feeling of hunger and in the function of alimentation. Animals that have been deprived of their stomachs still try to feed. We do not always need a perfectly marked appetite to eat. We often accept food out of politeness, in mere imitation of others, or because we think it reasonable, when we do not really wish for it. In a word, these authors are right in adding more elementary and more general disturbances to the fixed ideas of hystericals. They are wrong in stopping in this matter at the sensibilities of the mouth and stomach.

I wish a more thorough investigation might be made, in this connection, of a phenomenon that is as yet very imperfectly elucidated; namely, the excessive fondness for physical exercise that characterizes a whole group of anorexic patients. This character was already noted by Lasegue. It is well indicated in a short and unfortunately very incomplete article of Dr. Wallet.[1] "The patient," he says, "is exceedingly fond of long walks. As she is growing thinner with enormous

[1] Wallet, "Deux Cas d'Anorexie Hysterique," *Nouvelle Iconographie de la Salpetriere*, 1892, p. 276.

rapidity, they are forbidden to her. She then begins to walk, from morning to night, up and down the little garden of the house, which was likewise forbidden to her. Then she plays all day at shuttlecock. It is prescribed that she stay in her room; there she gives herself up to violent gymnastic exercises. Even in bed she goes on with her gambols and summersaults."

For my part, I was much struck with this odd phenomenon, which most authors merely indicate, without dwelling upon it. One of my patients, Mu., has had for years a mania of walking of at least as great gravity as her mania of refusing to eat. She must needs go every day on foot as far as the Trocadero and the Bois de Boulogne. The carriage has only the right to follow her. She tires the persons who accompany her. If a limit is fixed of two hours' fast walking a day, she makes scenes about the calculation of the minutes. No supplications or menaces can stop her walking, any more than they can stop her inanition. With a very singular woman, who has periodical anorexies consequent on the least emotion, the need of walking begins immediately with the refusal to eat. It happens suddenly; after the emotion, she refuses to return home, as well as to dine. This character is at least as strange as the first.

The first explanation of this fact was presented by Lasegue and by Charcot, and since then it has always been repeated without hesitation. These patients walk too much and take too much exercise by virtue of a piece of reasoning: they want to make those around them believe that they are still strong and robust, in

order not to be compelled to eat more. I confess this explanation does not satisfy me. Many patients, who spoke to me sincerely during or after their disease, have assured me that they thought nothing of the kind. Moreover, this exaggerated motion is to be found in aged patients who are left at liberty and whose alimentation nobody watches over.

Another curious explanation is that which was given by M. Wallet in 1892. The patient walks in order to grow thin, in order to compensate with the exercise he takes the alimentation that is imposed upon him. With this explanation we return to the initial idea of Charcot; namely, that all these patients want to grow thin. You know that it is not true, and that if in some particular cases this exaggeration of motion can be explained by such reasoning, it would be absurd to generalize the explanation.

I believe that the phenomenon in question is much more important and serious than these authors thought. It is not the result of a little particular imposition; it is connected with a very general disturbance. This disturbance first comprises the *suppression of the feeling of fatigue*, which is here much more important, in my opinion, than the anesthesia of the stomach. It comprises, besides, something that is very little known; namely, a general excitation to physical and moral activity, a strange feeling of happiness, an euphoria, according to the medical term, which are certain but very little studied facts. The need of food goes with the feeling of weakness and depression; persons depressed by neurasthenia are great eaters. The exal-

tation of the strength, the feeling of euphoria, as it is known in the ecstatic saints, for instance, does away with the need of eating. Our hysterical anorexy is to be traced to much deeper sources than was supposed.

This is how I propose to you to represent it to ourselves, without, however, pretending to explain it. The function of alimentation, if we consider it on its psychological side, is one of the most considerable systems of thoughts that exist in the brain of an animal. It comprises fundamental phenomena, such as the feeling of weakness, of depression, and the fear of death. Besides, it comprises numberless secondary phenomena, such as the sensations and motions connected with all the parts of the organism that play a role in alimentation, from the hands, lips, and tongue to the rectum and anus; lastly, it also comprises phenomena of improvement, as the images of pleasant aliments, the habits of eating cleanly, and the mixture of certain social phenomena that usually complicate our alimentation. There is in the hysterical a dissociation of this system, which may totally or partially withdraw from consciousness. In complete anorexy, you will find the loss of all the elements I have just described, the loss of the sensation of weakness, replaced by a pathological euphoria, the loss of the sensations of the organs, but also, more than is generally believed, the loss of the movements. These patients can no longer cleanly convey their food to their mouths, they can no longer masticate, and above all, they can no longer swallow, nor can they go to stool. There is, besides, a phenomenon which has not been much noticed and which consists in losses of the social

ideas of alimentation. Marceline was very amusing when she explained to me how ridiculous she thought the act of eating, how much she wondered to see people gather for this dirty operation. Hysterical anorexy is, at bottom, a great amnesia and a great paralysis. Alimentation has become, as it were, a somnambulistic phenomenon which can only be effected in the second or somnambulistic state, as happened with the last patient. This phenomenon is lost to the normal and waking consciousness.

III

Before concluding this lecture, I should like rapidly to add a few details, which it is necessary that you should know, but to dwell on which would take too long. The dissociation of which I have just spoken to you may bear on all the elements of which the function is composed, and suppress them separately. You have then kinds of paralyses or amnesias, as you choose, which may be connected with all sorts of organs. It is needless to enumerate them; you have only to follow the organs themselves. The hysterical patient may lose the functions of the lips in alimentation, as she lost them in speech. She may lose the functions of the tongue or those of the teeth.

Grant a little more attention to the functions of deglutition of the pharynx. Many of these patients can no longer swallow, and they should not be confounded with psychasthenics, who have the phobia of deglutition. Some of these subjects cannot make their food

pass from their œsophagus into their stomach. I am attending an old hysterical lady, and do you know what my first care must be when I see her after her lunch? It is to make her swallow her lunch, which she still has in her œsophagus. I am sure that the amnesia of defecation plays a role in many obstinate constipations.

What happens for the intestine is still more important and frequent for the bladder. You know that hysericals may lose all the functions of the bladder or only some part or other of them. Nothing is more important for a physician than to know thoroughly the neuropathic disturbances of micturition; he can render many services to unfortunate people and avoid many guilty mistakes. How many operations are performed on young women under pretence that their urethra is either too big or too narrow, when their urethra has nothing to do with their urinary awkwardness. They can no longer either begin the micturition, or stop it, or control it, and you have varieties of incontinence or retention that may become exceedingly complicated.

This rapid review of the dissociation of the functions of alimentation confirms my general studies on hysterical paralysis and amnesias, and gives us the plan of our next lecture on respiratory disturbances.

LECTURE XII

THE TICS OF RESPIRATION AND ALIMENTATION

Respiratory paralyses — The problem of hysterical asphyxia — Respiratory anesthesia — Respiratory disorders — The rhythm of Cheyne-Stokes — The paralysis of the diaphragm with alternating see-saw respiration — Respiratory agitations — Polypnœa — Inspiration tics — The sigh, yawn, hiccough — Aerophagia — Expiratory tics — Hysterical cough — Laughter — Hysterical bark — Complex tics — The meteorism of the abdomen — The tics of alimentation — Bulimia — Polydipsia and polyuria — The spasms of the jaws, cheeks, pharynx — The tic of eructation — The tic of regurgitation — The tics of aspiration — Hysterical vomiting — The vomiting of blood

We have to repeat in regard to respiration a study analogous to that which we devoted to the functions of alimentation; the phenomena are about of the same kind, though they are of less gravity. On the other hand, they are of infinite variety, and we might dwell indefinitely on the *apnœas*, *dyspnœas*, *suffocations*, *respiratory disturbances*, on the varied *respiratory paralyses*, on the innumerable *tics*, *polypnœa*, *yawn*, *sigh*, *sob*, *hiccough*, *cough*, *sneeze*, *bark*, *shakes of the abdomen*, *meteorism*, without counting *the tics of the organs of alimentation*, which I should like to place by the side of the latter, namely, *eructation*, *regurgitation*,

borborygms, vomitings, etc. Do not be too frightened; we shall be brief on all this, for, the general rules once known, these various phenomena are always similar to one another.

I

Let us first speak of the *respiratory paralyses*, and, to illustrate our teaching, let us at once place a very curious example before your eyes. The case was published a few years ago by M. Lermoyez, a distinguished specialist in diseases of the nose and larynx.[1] Being very interesting as regards the theory of hysteria, and being described simply, without any preconceived idea, by a physician who has not made a specialty of the diseases of the nervous system, and who is not engaged in the quarrels of our schools, this case should have attracted the attention of scientists much more than it did.

A girl of about twenty was taken to M. Lermoyez because her nose was obstructed by adenoid vegetations, which disturbed her respiration and attention. The vegetations were not very big, and the operation was effected without any difficulty. But it was noticed that the girl did not breathe better than before, that, in particular, she was obliged to keep her mouth open, which dried her tongue and lips. M. Lermoyez thought the nose was still obstructed; so he examined it minutely, but he discovered nothing, for the respiratory channels were wide open. Wishing to prove to the

[1] M. Lermoyez, "Insuffisance Nasale Hysterique," *Societe Medicale des Hopitaux de Paris*, January, 1899. *La Presse Medicale*, January 25, 1899.

girl that she breathed very well through her nose, that she kept her mouth open needlessly and out of habit, he applied his hand on her mouth, with the idea that she would simply breathe through her nose. To his great surprise, it was not so. There was no breath through the nostrils, the patient writhed as if she were choking, and, as he insisted on her trying again, while she was being held fast, her face and ears turned blue. In a word, this girl suffocated when you shut her mouth, while leaving her nose open. There was, however, no obstacle at any point, there was only a singular disturbance of the nervous system, *an incapacity of effecting the respiratory motion*, of moving her chest in the least as soon as the mouth was shut. As M. Lermoyez very rightly said, this girl had forgotten how one manages to breathe through one's nose. Can a finer confirmation be found of our teaching on functional paralyses and amnesias? Have we not there a pretty dissociation of the respiratory function, or at least of one of the parts of the respiratory function? This example at once shows you that we shall find the same problems in the study of respiration.

Yet it is incontestable that we cannot begin with so important and so definite a disturbance as anorexy. The latter was, as we saw, the suppression, the dissociation of the whole of alimentation, going as far as inanition and death. It was the great functional paralysis. Is there a corresponding absence of respiration, a corresponding *asphyxia* suppressing all respiration and going as far as death?

The point is moot; you may see the opinions for and

against it in the book of M. Gilles de la Tourette.[1] For my part, I hesitate to admit that it can be true. I have seen several persons die of hunger; I have not yet seen any one die of suffocation. Hysterical asphyxia, resulting from various disturbances in the respiratory mechanism, does not seem to us to be capable, in general, of bringing about death. A moment comes when asphyxia brings on fainting; that is, the arrest of the higher functions of the brain, and the respiration, being no longer impeded by these higher functions, is restored owing to the automatism of the bulb.

Therein lies, in fact, the difference I indicate to you between the alimentary and respiratory disturbances. Alimentation, or at least the mechanical part of it, consisting in the prehension of aliments, is entirely a conscious, voluntary function. Even if we die of hunger, if we are in a swoon brought on by inanition, no bulbar mechanism will cause us to eat. Whereas respiration is not entirely a conscious and voluntary function. Consciousness may disturb it greatly, no doubt; we shall see how many foolish things it may do; but, happily for us, there is outside our consciousness a fundamental mechanism, which is the safeguard of our hystericals. This difference between hysterical anorexy and hysterical asphyxia as regards danger is still another fact to be pointed out in order to justify our mental interpretation of the disease.

However it may be, there exist hysterical disturbances of respiration, which fact we understand very well now we know the influence of the brain on

[1] Gilles de la Tourette, "Traite de la Hysterie," 1895, II, p. 124.

this function. Flourens in 1842 connected respiration entirely with the bulb, but since the works of Coste in 1861, of Danilewsky in 1875, of Lepine, of Richet, of Franck, of Pachon, and especially of Mosso, we know very well that there is a cerebral respiration. When the brain is benumbed, the respiration decreases and is reduced; it seems that in total respiration there is a part of superfluous respiration or respiration of luxury, as Mosso called it, which depends on cerebral activity. It is this respiration of luxury that hystericals can modify in a thousand ways.

We first find *disturbances of the respiratory sensibility*, which, of course, play a fairly important part in the evolution of the accidents, for you know that every loss of a function or every paralysis is accompanied by an unconsciousness, relative to the special sensations that play a part in the function; that is to say, with a systematic anesthesia. You will often find more or less *diffuse anesthesias distributed over the organs of respiration*. The nose is very often insensible, and the absence of the perception of odours — anosmia — accompanies the respiratory disturbances as well as the disturbances of alimentation. The pharynx is very often insensible. You know that formerly Chairon wanted to make this insensibility, and the loss of the pharyngeal reflex to tickling, a symptom characteristic of every hysteria. This is very exaggerated, though the fact is frequent, since it accompanies the disturbances of alimentation and those of respiration. You will find disturbances of sensibility distributed over the thorax and abdomen.

What is more interesting, you will be able, in certain cases, to recognize a very special anesthesia relative to respiration itself. We feel our respiration, and, above all, we feel the need of breathing. M. Bloch in 1897 invented a curious apparatus for measuring this respiratory sensibility. The subject is obliged to breathe through a tube the end of which is closed by a window of calculated dimensions. A screw allows you gradually to reduce the dimensions of the window, and the subject, whose eyes are shut, must indicate at what moment he feels a difficulty in breathing.

The figures obtained vary pretty much with the subject, the hour of the day, and the movements the subject has just made, but I have been able to observe that in hystericals the figures are often very different and infinitely smaller. The patient indicates only very late the need to breathe, much later than a normal individual would do, when she is already half suffocated. This phenomenon shows *a special unconsciousness of the respiratory need*, which is to a certain extent comparable to anorexy; that is to say, to the unconsciousness of hunger.

These disturbances of the sensibility are accompanied with motor disturbances of which the subjects are more or less conscious. They can no longer breathe voluntarily, though they do not arrive at total asphyxia for the physiological reasons I have pointed out. They can no longer add to their respiration that luxury to which we are accustomed. The subject complains of feeling oppressed, of feeling contracted in her neck, in

her chest, of suffocating, of not being able to make air enter her chest. Sometimes these phenomena are consequent on accidents bearing on the respiratory organs, — we have just seen this in the case of Lermoyez, — and the least cold in the head may cause similar phenomena in the patient in question. Sometimes they are consequent on any emotion whatever, disturbing the respiration, which the subject cannot restore. In many cases, the respiration, abnormal during the waking state, very quickly becomes normal again during the somnambulistic state or the periods of absent-mindedness. The accident is quite conformable to the rules that apply to paralyses.

You should not believe, however, that these facts are connected with real paralyses of such or such an organ of respiration. The paralysis is less definite here than in alimentary disturbances, again for the same reason. A most interesting phenomenon which I have very often recognized in this connection is a *respiratory disorder*, an absence of regularity and harmony. Respiration depends on complex organs, the nose, the pharynx, the glottis, the thoracic cavity, the diaphragm; it cannot be effected correctly if everything does not work at the same time and in the same direction. It is useless to dilate your thorax if you shut your glottis or swell your diaphragm. This is what our patients do. The efforts they make in their various organs are contradictory, and that is the reason why they make only very little air enter their chest, in spite of apparently considerable efforts. Bear this detail in mind; you must not think that people breathe very much when they agitate their

chest very much. Spirometric measures show us that hystericals breathe very little in reality, in spite of great apparent heavings of their thorax and abdomen. Their respiratory disturbance is less a paralysis proper than a want of synergy. This is also interesting for the comprehension of their paralyses, which are, as I have told you, paralyses of a system. One may no longer be able to ride a bicycle without having any apparent paralysis of the legs.

In certain cases, however, the respiratory disturbance may assume more determinate forms, which have greater resemblance with known paralyses; but these facts are rare and still discussed. I merely indicate to you the problem. I, myself, communicated to the Congress of Psychology, held in Paris in 1900, a fact which is very important in my opinion, namely the appearance of *the rhythm of Cheyne-Stokes* in hysteria.[1]

You know, that about 1816, Cheyne of Dublin and Stokes described a certain quite special irregularity of respiration, which, to their mind, was characteristic of the most serious states. As you see on this table (Figure 16), this rhythm is characterized by respiratory pauses; there is a series of ten to fifteen quick breaths, then an arrest of the respiration which may last long, half a minute in some cases; then the active respiratory series begins again. At the outset, this phenomenon was only established in cerebral apoplexy, in most forms of agony,

[1] F. Raymond et Pierre Janet, "Un cas du rhythme de Cheyne-Stokes dans l'hysterie, influence de l'activite cerebrale sur la respiration," *Comptes rendus du IV^me congres international de psychologie*, tenu a Paris en Aout 1900; 1901, p. 524.

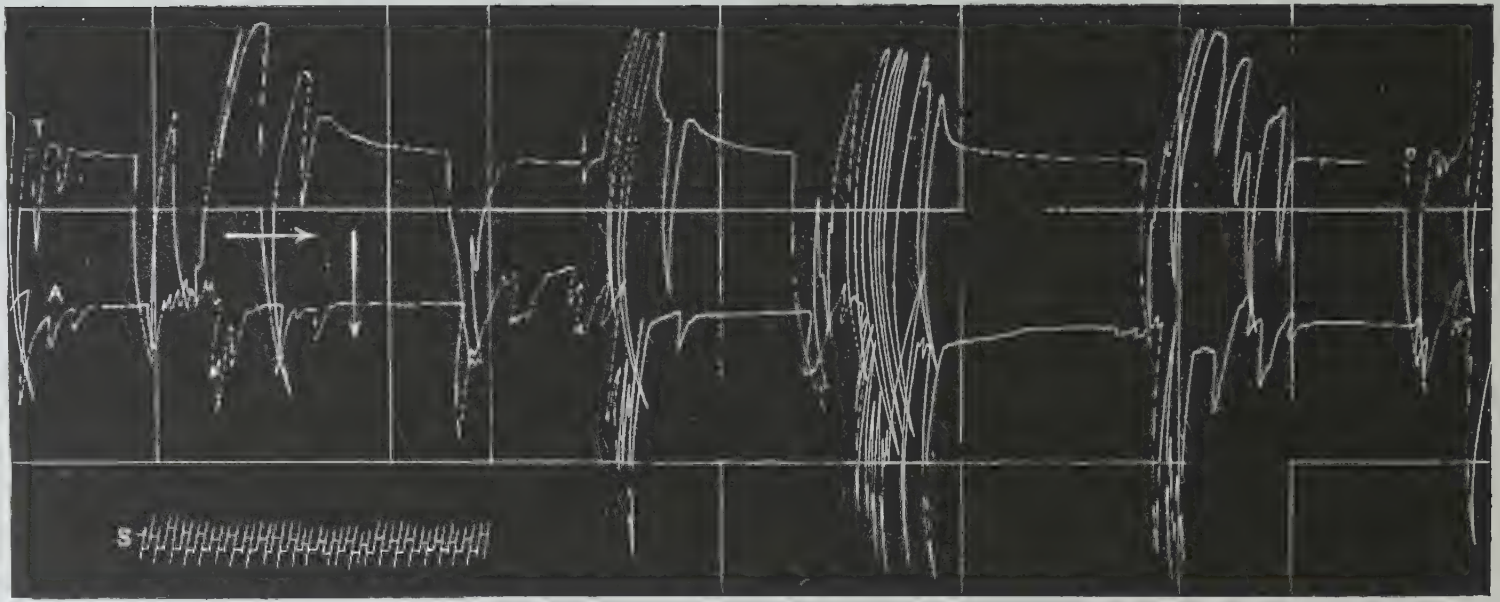


FIG. 16. — Graphic of the respiration in a case of the rhythm of Cheyne-Stokes in a hysteric woman. *T*, thoracic respiration; *A*, abdominal respiration; *S*, the time in seconds. The horizontal arrow indicates the direction in which the graphic must be read, the vertical arrow the direction in which the inspiration is inscribed.

in certain varieties of cerebral tumours. Later on, it was also found in typhoid fever, in uræmia, in various intoxications. M. Mosso was the first to generalize this respiratory rhythm singularly; he showed that it existed in simple natural sleep when profound, and, in general, in all states of general numbness.

At a time when I used to take systematically and with some exaggeration the graphic of the respiration of all the hystericals I attended, I was very much astonished to find with one of them a graphic which exactly presented the rhythm of Cheyne-Stokes. I refer you to my article if you wish to see studies which are not without interest on the modifications of this rhythm. This patient was always in a state of absent-mindedness and revery. When her attention was attracted through any process, her respiration changed and became again nearly normal. It is the same in the other cases of Cheyne-Stokes that I found in hystericals. This respiration exists in subjects who are in a condition of half-sleep and who are incapable of any attention. It vanishes when the subject is more awake and more active. These observations are interesting in that they show the role of respiration in attention. They are also important for the theory of hysteria, for they show us here the disturbance of a function, that of attentive respiration, which is not a function known to the subject and which consequently cannot be disturbed through preconceived ideas.

In the same order of ideas, I wish to indicate to you, rather as a curiosity, for this time I have seen only one case of the phenomenon, *a paralysis of the diaphragm*

with alternating see-saw respiration. You know that, in normal respiration, the diaphragm falls when the thorax rises, actively forces down the intestines, and consequently swells the abdomen during each inspiration. If the diaphragm is paralyzed, it cannot perform

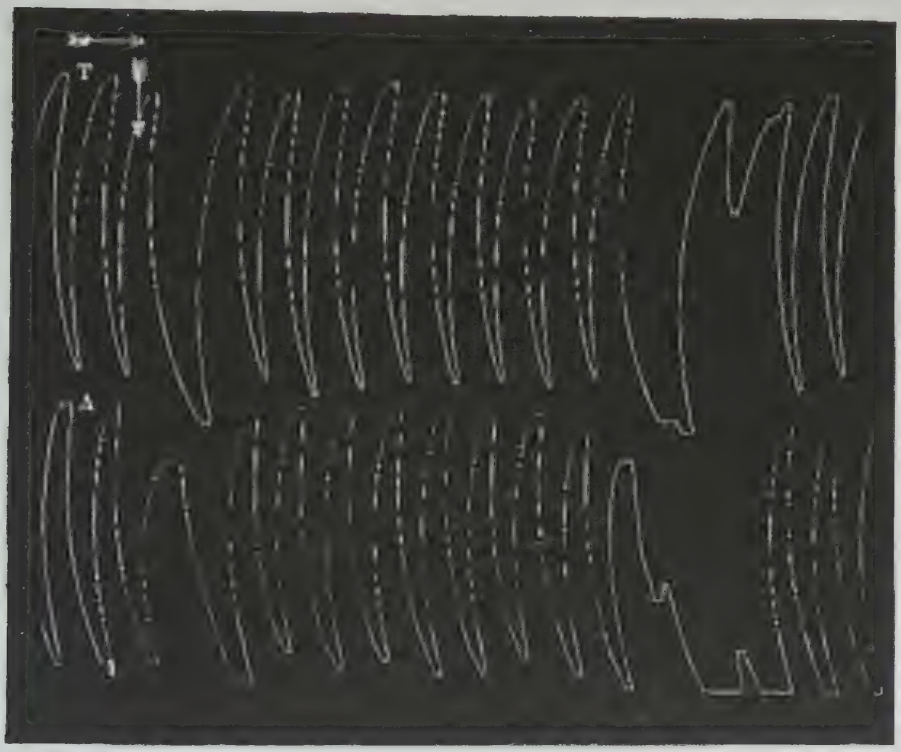


FIG. 17. — Graphic of the respiration in a case of polypnœa, 80 respirations in a minute, and of discordant respiration. The signs have the same meaning as in the preceding figure.

this active movement; it floats like an inert veil, and allows itself to be drawn up during each thoracic inspiration; the abdomen hollows inwards instead of swelling when the thorax dilates: that is what is called see-saw respiration. It was formerly considered as very dangerous and incompatible with life. Briquet already

vaguely indicated an instance of it in a case of hysteria. I have very accurately described an observation of this phenomenon relating to the girl whose whole trunk was paralyzed in consequence of a fall into a well.[1] You see in this graphic (Figures 17 and 18) that the respiration is very quick, 80 respirations in a minute, and that the graphic of the thoracic respiration, *T*, and of

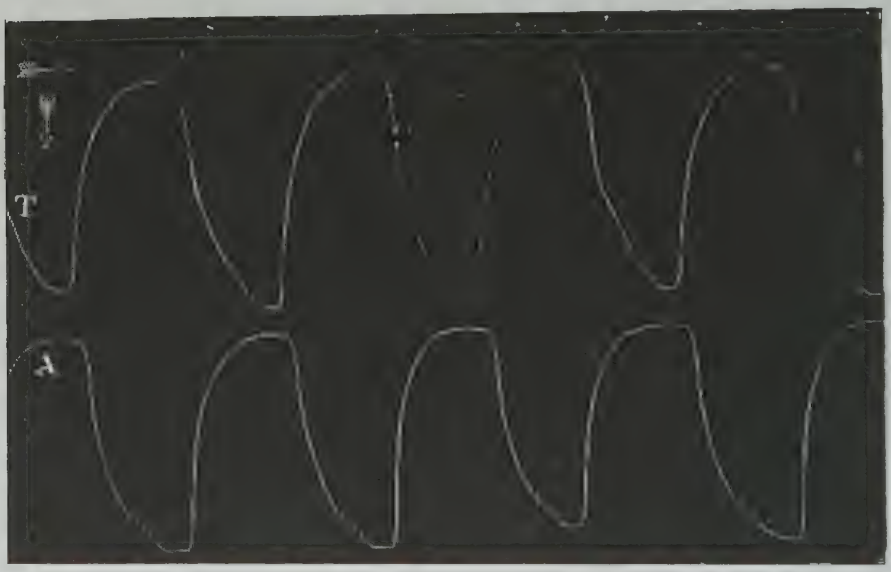


FIG. 18. —Another graphic of the same respiration taken with increased speed of the registering cylinder, in order to put into evidence the discordance between the thoracic (*T*) and the abdominal (*A*) respirations.

the abdominal respiration, *A*, are not parallel, but discordant. The abdomen hollows inward instead of swelling when the thorax dilates, which I have pointed out as the sign of the paralysis of the diaphragm. The young patient of this case had undoubtedly a number of hysterical accidents, and this phenomenon was, I think, of the same kind. But it is, I own, a phenomenon

[1] "Nevroses et Idees fixes," I, p. 329; II, p. 414.

whose presence in hysterics is still open to discussion. If this presence is confirmed, we shall be obliged to admit more profound, older functions relative to the movement of the diaphragm, which may be troubled in certain serious forms of hysteria as old functions are disturbed in hemiplegy and hemianopsia.

II

To those paralyses of the respiratory function are added, as is always the case, and according to the rule we know, automatic agitations. The functions are never entirely lost in hysteria; they are emancipated. In this state they are performed in a more or less absurd manner, without the will of the subject. As there are in the respiratory function a quantity of small distinct functions, each of them may emancipate itself separately and give rise to very varied tics.

Let us put in the first rank the exaggeration of total respiration, *polypnœa*. Here is a fine case. A is a man of thirty, a foreman in a seaport. One day he was commanding some workmen who were working a capstan in order to raise a tall mast. He saw a rope break and the mast incline, and fancied that it was falling on his workmen, which caused him to utter loud cries. No accident occurred, but he was so fatigued with this emotion that he was obliged to return home. The next day it was noticed that he breathed in an odd way; the respiratory disturbance grew little by little and turned to a great polypnœa which lasted several months. He kept on breathing with unheard-of quick-

ness and force; his chest heaved very strongly and very quickly without any interruption. He had 88 then 97 respirations a minute, instead of the normal 18 (Figure 19). This formidable respiration exhausted him, threw him into a perspiration, and above all did not leave him the least freedom of mind. He sat motionless on his chair, thinking of nothing, doing nothing but breathe. Notice also that continual parallel of the dis-

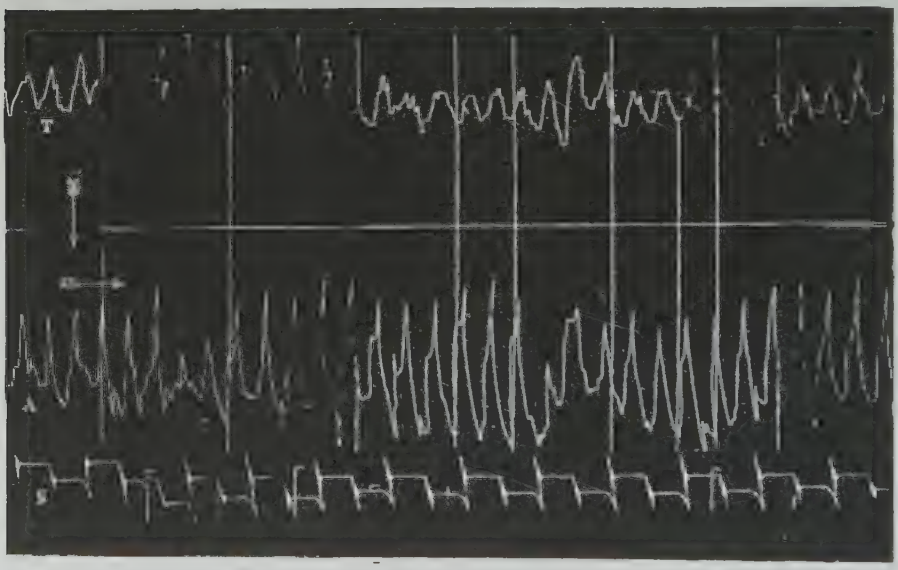


FIG. 19. — Graphic of the respiration in the case of polypnœa of A.

turbances of respiration and those of attention. As soon as he was hypnotized the respiration became calm, and he was very quickly cured through this process.

But note in passing a fact to which we shall revert later on: our patient remained cured for two years, then he lost a little daughter, and do you know what disturbance he was affected with in consequence of this grief? Was it a somnambulism or a crisis, as was the case in so many of the patients we passed in review?

No, it was the same polypnœa which began again and had to be cured through the same process. By the side of this case might be put that of a girl who breathed seventy times a minute after suffering an attempt at rape, and many of the same kind.

After those exaggerations of the total respiration, let us rapidly enumerate the exaggerations of details, the tics bearing on such or such a particular function. Let us first consider *inspiration tics*, exaggerated inspiration, which is connected with a certain degree of dyspnœa, and will assume the form of continual *sighs*. When a little stronger, it will be a *sob*, then a *yawn*. You know what importance was formerly attributed to the hysterical yawn, which was thought very amusing. Nothing, in fact, is more singular than those poor girls who, all day long, and two or three times a minute, yawn till they almost disjoint their jaws. It is one of the phenomena in which the imitative contagion is best exhibited; it is also a phenomenon in relation with the disturbances of alimentation.

It is the same with the last inspiratory tic, the *hiccough*, which is also very frequent. The hiccough is nothing but a very rapid inspiration with a certain degree of spasm of the glottis. The air cannot reenter quickly enough, because the inspiration is too rapid and also because the glottis is a little closed; this results first in a certain characteristic noise, and also in a certain thoracic vacuum, which causes an aspiration in all the organs. You can see this fact in the graphic of hiccough (Figure 20): when the hiccough appears at the beginning of each inspiration, the abdomen is aspirated and the

graphics of both respirations, thoracic *T* and abdominal *A*, are momentarily discordant.[1]

This will presently play a great part in the phenomenon of *aerophagia*, with patients who swallow air, and in vomition. Let us only remark that the hiccough is one of the most frequent phenomena. When looking

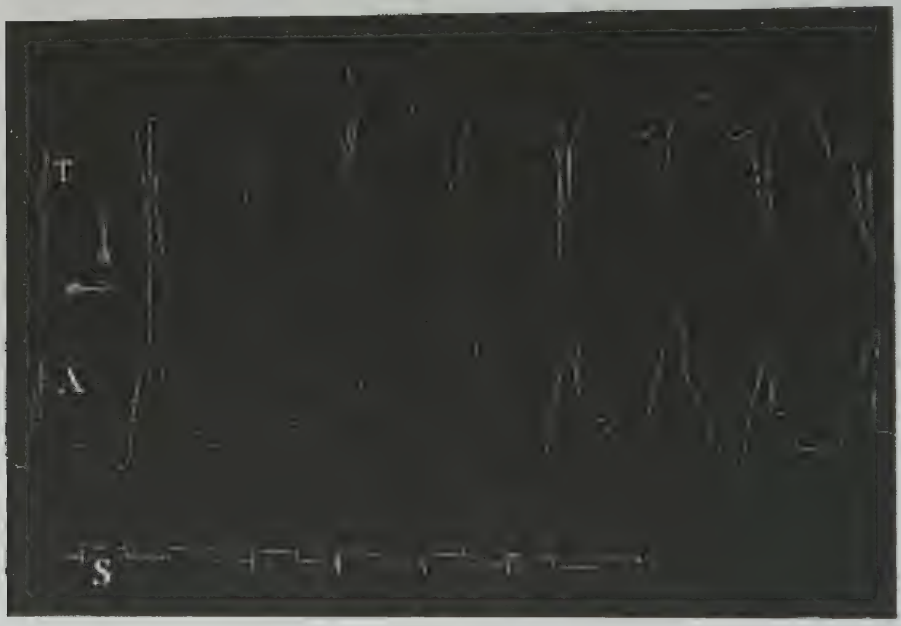


Fig. 20. — Graphic of respiration in a case of continuous hicough. A hiccough in each respiration at the beginning of the inspiration.

over my notes to prepare this course of lectures, I counted twenty-nine great observations of hysterical hiccough that had lasted for months together.

Among the expiratory tics, we shall first range the hysterical cough, that little phenomenon so frequent at the outset of the disease. There are, in this connection, clinical observations on the evolution, which are facts of experience and cannot very well be accounted for.

[1] "Nevroses et Idees fixes," II, Observation 100, p. 360.

Thus the hysterical hiccough is, to my mind, a rather serious phenomenon of bad prognosis. It points to a great hysteria; the hysterical cough, which is almost like it, is a more commonplace and less serious phenomenon. Almost every girl has had an irrepressible cough in consequence of a certain cough, of efforts in singing, or of fits of bashfulness. When the phenomenon is isolated, it is very difficult, in my opinion, to say whether we have to deal with incipient hysteria or with a mere psychasthenic tic. As always, pay attention to the state of the sensibility, to the degree of the unconsciousness, and to the effects of distraction.

One degree further: you have hysterical *laughter*, those interminable crises of laughter which develop for hours together like real fits of hysterics. You know the psychological problem of laughter, and are aware that this phenomenon, apparently so amusing, is a torturing problem for the unfortunate scientists. You should not fancy that laughter is always the expression of joy. Certain hysterical laughters are of this kind. Thus a girl of bad morals had undergone a little surgical operation for which she had been half chloroformed, but, during this trifling operation, young students of the hospital, who surrounded her, had kept joking her and making her laugh. Probably under the influence of the chloroform, this laughter was transformed into an independent automatic phenomenon, and persisted as a tic.[1] But, in other cases, laughter accompanies pain; it accompanies nervous exhaustion and is to be observed in great delirious attacks. It is probably a

[1] "Nevroses et Idees fixes," II, Observation 98, p. 352.

phenomenon of derivation of the nervous strength very difficult to account for.

One degree further, and the expiration, more violent and accompanied with spasms of the glottis, will bring about the most varied cries, the famous *hysterical barks*. You know that they occurred epidemically in the Middle Ages, and that, in the convents, nuns began by hundreds to howl, bark, or mew. It was necessary to threaten them with a hot iron to silence them. It is by far less widespread nowadays and is not so epidemic, but nevertheless it exists very often under various forms. In many cases, this tic is mixed with some phenomena of disturbances of speech of which we have already spoken. Little by little, the bark becomes a particular word, the name of a person, or some obscenity or other.

You understand, in fact, that all these various tics we have analyzed may be mixed with one another and give rise to complex phenomena. One of the most interesting is that to which I alluded just now when speaking of the hiccough. The hiccough, through the vacuum it determines in the thorax, produces a draught in the œsophagus and causes the subjects to swallow air. After three or four hiccoughs, the stomach is full of air, which brings about another fact; namely, the expulsion of those gases from the stomach through an eructation. Therefore, as you may easily notice, great hiccoughs are always interrupted now and then by eructations of different tones. I used to note down in the following manner the noises that one of my patients regularly made: "nioup, nioup, nioup, zaa," and thus indefinitely. This same patient complicated her respiratory dis-

turbances a little by adding to them disturbances of speech. Thus, the noises of her hiccough were often transformed into veritable words; now and then, she would repeat: "all right," and "all rock," which sounded about like the name of her medical attendant. It even appears that the noise "nioup, nioup" had been consequent on the reading of a novel in which some savages sang: "iou, iou."

With those same complex tics of respiration I should like to connect an exceedingly curious phenomenon; the swelling of the abdomen or meteorism. It is necessary that you should know this phenomenon well, because it is the one which gives rise to the most common and grotesque medical errors. You know of those newly married young women who long to have a child; the menses are suppressed, the abdomen becomes big and hard, the breasts hard and coloured; there are nauseas and vomitings. A midwife is called in. She feels the arm of the child and fixes the date of the delivery. This date comes and nothing ceases; the expectation continues. One fine day, everything disappears, without its being possible to know what has become of the child. It is the famous nervous pregnancy, of which I have noted down about ten cases, and of which one should beware. The error is less serious here than when these swellings of the body are attributed to various tumours, and operations are counselled.

However that may be, this abdominal swelling is not very easy to account for; the old theories of the time of Charcot connected it with a paralysis of the intestinal walls, admitting of the dilatation of the gases. I am

much more inclined at the present day to believe that it is due to respiratory phenomena. One of those phenomena is a spasm of the diaphragm, which remains lowered and compresses the viscera forward; but it only brings about the smaller swellings. The other is in relation with that same aerophagia which I have just mentioned. Certain patients eject the air they have inhaled by means of eructations. Others do not succeed in emptying their stomach through the upper end; they force their pylorus open and send this air into their intestine, which determines varied disturbances of the digestion, and, in particular, diarrhœa, but, at the same time, a sometimes enormous swelling of the whole abdomen. You may imagine many other combinations of these respiratory disturbances.

III

But, before leaving the subject of visceral disturbances, I should like to tell you briefly of some other very important tics which depend on the function of alimentation, of which we have spoken. Most of these tics of alimentation besides are at the same time complicated with a respiratory phenomenon.

In the first place, the function of alimentation, emancipated from the personal consciousness, may become exaggerated and give rise to various forms of *bulimia*. Patients affected with bulimia cannot stop eating; they constantly ask for food. The fact of bulimia, it is true, exists in hysteria, but be on your guard; it mostly belongs to psychasthenic impulsions.

It is to be met with among those patients who feel weakened, depressed, and have taken the mania to revive themselves by some stimulant or other, adopted more or less at haphazard.[1]

Some have the mania of always eating; others — and they are the most numerous — have the mania of drinking alcohol. Yet there is one form of those manias which is in relation with a hysterical phenomenon, and which it is right that you should know. It is *polydipsia*, which is not to be confounded with dipsomania. The dipsomaniac seeks after exciting drinks and it is alcohol he wants to swallow. The polydipsical is not so hard to please; he is content with pure water, but he swallows twenty liters of it a day. This excess of drink has an inevitable consequence; namely, an excess of urine, *polyuria*. Some of these patients discharge eighteen liters a day. Curiously enough, more stress has generally been laid on this consequence of the phenomenon than on the phenomenon itself. Polyuria was studied among the disturbances of the renal secretion to be met with in neuropathic patients. I think it should rather be connected with deliriums or with the disturbances of the functions of alimentation, which bring about the impulsion to drink indefinitely.

But after those great automatisms of the function of alimentation, we have to point out a host of partial disturbances, *spasms of the jaws and cheeks, spasms of the pharynx, tics of perpetual spitting and salivation.*

[1] Pierre Janet, "On the Pathogenesis of Some Impulsions," *The Journal of Abnormal Psychology*, edited by Morton Prince, April, 1906, p. 3.

Ptyalism, which is frequent in certain melancholy deliriums, exists also in hysteria. I do not insist on the spasms of the œsophagus, to which we alluded in our last lecture. You also know *the tics of eructation* and the belches, of which I have just spoken to you in connection with the hiccough. But I must point out to you a complication of the phenomenon, which is called *regurgitation, merycism.* Some of these patients learn to ruminate like cows. They know how to bring back into their mouths the food they have swallowed. It has been said that this constituted an odd physiological phenomenon, in which the movement of the œsophagus was reversed. I think, rather, that it is one of those curious phenomena of *aspiration*, induced by abnormal respirations. By making a movement of aspiration very quickly while shutting the glottis and preventing the air from entering into the lungs, one induces a vacuum in the thorax, which can react on all sides. A certain individual, who was formerly celebrated in Paris, thus drew up air through his anus and knew how to eject it in a melodious way. We know that many thus draw air into their œsophagus. But the aspiration into the œsophagus may be effected in the opposite direction and throw up the contents of the stomach. We shall see this mechanism assume a greater importance still in the following phenomenon, the only one that is really important; namely, hysterical vomiting.

Hysterical vomiting is almost as serious as anorexy itself. It is certainly responsible for several deaths. It almost always complicates all the preceding disturbances. This vomiting is rarely pure; that is to say, it

rarely depends on hysteria alone. Nowadays, as I told you at the outset, the attention of physicians is much more directed to associated hysteria, to the organic affections that are at the starting-point of hysteria, or its localizations. Lately, MM. Mathieu and Roux, in a paper in the *Gazette des Hopitaux*,[1] again insisted on this point in connection with hysterical vomitings. Almost always, they said, there is at the starting-point some organic affection which induces the beginning of the phenomenon. This *primum mobile* may be either the vomitings in pregnancy, or alcoholic gastrites, or gastrites of any kind, or, above all, ulcers of the stomach, of which we shall have to speak again.

But, however it may be, what characterizes the phenomenon is the exaggeration and regular and indefinite reproduction of the vomiting long after the action of its cause. This vomiting, in fact, is exceedingly rapid and easy; it immediately follows the meal; it is accompanied with very little nausea and no effort. It is repeated with any kind of food and produces the most dangerous inanition. It is also in cases of this kind, that the tuberculous complications supervene which almost always terminate hysterical inanitions. A rather characteristic phenomenon is that the patients cannot seem to endure the arrest of the vomiting. When, through any process, they are prevented from vomiting, they exhibit anguish, are agitated, writhe in every way, complain of a thousand sufferings, and finally become unconscious in a great hysterical attack.

[1] A Mathieu and J. Ch. Roux, "L'Hysterie Gastrique," *Gazette des Hopitaux*, February 22, 1906.

Many patients have thus to choose between delirious attacks and perpetual vomiting. This is quite the character of an automatic agitation which they can no longer control.

Formerly an apparently very serious accident was always brought close to hysterical vomiting, namely, *the vomiting of blood*, and these hematemeses were unhesitatingly connected with hysteria. It had been noticed, and that very rightly too, that these hematemeses almost always coincided with the beginning of the menses, and it was usually said that these women have their menses through their stomachs. At the present time, this notion of these neuropathic gastric hemorrhages tends to become obliterated, and physicians are inclined to say that they are due to an unrecognized ulcer of the stomach. The symptoms that were formerly indicated as conducing to the diagnosis seem to have lost something of their value. The pain occurring long after the meal, the irregular paroxystic crises, the relation with the menses, even the relation with moral emotions, all that was found again in the ulcer. Kuttner in 1895 pointed out a patient whose first vomiting of blood came on after the death of a relative. He was led to cut open her stomach and found a real ulcer. Another woman, after a scene in which her daughter left home forever, had a vomiting of blood which formerly would have been unhesitatingly connected with emotional neuropathic disturbances. Her stomach was also cut open, and an ulcer was found. It is in the work of MM. Mathieu and Roux that you will find a very well-conducted discussion of this fact. The authors, how-

ever, hesitate to make a complete denial of purely hysterical hematemeses. They admit it in hemorrhagic pituites, in pituitous vomitings tinted with blood, in hematemeses coinciding with multiple hemorrhages of the skin, of the ear. Then why should it not be admitted that, in certain cases, this disposition to hemorrhage may be localized in the stomach?

Be very prudent, however, in this diagnosis, which, at the present time, must be less readily accepted than formerly. The same prudence, even still greater prudence, is, of course, necessary when you have to deal with fecaloid or still stranger vomitings which some of those subjects may exhibit. They are almost always due to simulations or deliriums, which you must know how to recognize. The real tics of alimentation and respiration we have just described are numerous enough for us not to complicate their list with doubtful phenomena. One of the characteristics of the present study of hysteria is that efforts are made to limit the disease more clearly than formerly and to leave out mysterious phenomena or phenomena depending on another malady. Our enumeration of the symptoms of hysteria is already complete enough, and we can now enter upon more general studies on the common characteristics of these diseases.

LECTURE XIII

HYSTERICAL STIGMATA — SUGGESTIBILITY

The need of unity in presence of the diversity of hysterical phenomena — The problem of the stigmata — The stigma of anesthesia — The historical importance of this stigma — Its exaggeration — The two meanings of the word "stigma" — The psychological stigmata — The character of hystericals — Instinctive falsehood — The mental stigma of suggestibility — The distinct meaning of the word "suggestion" — Description of the principal facts of suggestion — The complete development of the elements contained in an idea, without any participation of the will or of the personal consciousness — The distinction between real suggestion and normal phenomena — The conditions of suggestion — The systematization of images — The absence of suggestion properly so-called with normal people — The weakening of consciousness, the lack of synthesis — Suggestibility as a sign of hysteria — The disappearance of suggestibility after recovery from hysteria

The examination, even rapid, of the numerous accidents of hysteria raises inevitable problems in our minds. The most important one, the one that always torments the human mind in all possible studies, is the problem of unity, of the conception of the whole, of the essential and fundamental character. The first authors who described hystericals were always struck with the diversity and complexity of their symptoms. "It is

not a disease," said one of them, "it is a host of ailments." And you know that, to express the changeableness of hysteria, Sydenham called it "that Proteus that cannot be laid hold of." Sometimes it takes the form of deliriums such as we have seen in somnambulisms, and we are in the domain of mental diseases. Sometimes it presents accidents of the arms and legs, which make us think of articular and muscular lesions. Now we meet with disturbances of the stomach or lungs, and we have to deal with visceral diseases, gastrites, and pneumonias. You may understand the perplexity of the first clinicians, the best of whom came to abhor and loathe such a malady. They did not seek to take away from it its bad renown, for their scientific dissatisfaction discomposed them, made them impatient with the subject, and inclined them to call him a simulator and a debauchee. Slow was the reaction against this tendency, brought about by a very natural perplexity. The best answer has been to make hysteria intelligible, and, above all, to seek to give it some unity, by linking together those scattered accidents, by finding in all of them some fundamental features, which serve at once to explain them, to connect them with one another, to diagnosticate and to identify them.

This need of unity under diversity, which has never been so serious as in the study of hysteria, has enlarged with regard to this study a problem that, upon the whole, exists in every medical research: the problem of *the stigmata*. If one admits that somnambulism, paralysis, vomiting are, all three of them, hysterical phenomena, in spite of their enormous differences, there

must be something common among them. In the three patients a common character must be found, which is with all of them the starting-point of the observed symptom and serves to diagnosticate the hysterical character of this accident. That common character is the stigma, and one may say that, since the beginning of the scientific study of hysteria, all the attention of clinicians of any merit has been directed to the study and search of the stigma.

I

Of course this stigma has varied very much, for it reflects the theories of each period on the diseases one considers. Now this essential stigma of hysteria was the convulsive attack, now the hysterical bawl. You will read with astonishment the books of the beginning of the nineteenth century, in which you will find that hysteria is recognized from the bawl of nervous women. For about fifty years past, other more important characters have become predominant, and you are aware that, especially under the influence of the school of Charcot, one symptom has become the preeminent stigma; namely, *anesthesia.*

The singling out of this symptom was, in some degree, an unconscious return to the past. In the Middle Ages, people had also a kind of diagnosis to make, in order to recognize witches and those possessed as well as possible before burning them, and you know the singular method they made use of. A surgeon or an expert woman examined the body of the sufferer on all sides,

testing the sensibility with a sharp needle in order to discover *the devil's claw*, that insensitive patch which was a certain sign of witchcraft. They examined every nook and corner, for the devil is in the habit of concealing himself in the most hidden places, and they actually tested the sensibility of the mucous membranes as well as that of the skin. The fact is really very curious and shows an instinctive medical perspicacity that has not been sufficiently celebrated. Well, Charcot nearly brought us back to the time of the celebrated inquisitor Bodin, and, in our clinics, we are somewhat like the woman who sought for witches. We blindfold the subject, we turn his head away, rub his skin with our nail, prick it suddenly with a hidden pin, watch his answers or starts of pain; the picture has not changed.

This research has allowed clinicians to establish that, in many cases, various anesthesias accompany most hysterical symptoms. In the case of paralyses or contractures of the limbs, the phenomenon is very clear and regular, whether in regard to cutaneous sensitiveness, or, better still,—for it is very important,—to muscular sensitiveness. In the case of sensorial accidents, the anesthesia is very often quite distinct at the periphery; sometimes it conceals itself by taking extremely interesting forms, which the inquisitors did not know how to seek for, such as the contraction of the visual field. In the case of visceral accidents and of certain motor disturbances which are rather agitations than paralyses, the question becomes more delicate. Often the superficial anesthesia of the region indicates

the diseased organ, but, to be sincere, this is not always true. When we have to deal with the great mental accidents, with all the innumerable forms of somnambulism, the anesthesia sought for by Charcot is often to be met with, but it does not constitute the absolute rule.

That method which consisted in characterizing hysteria by anesthesia and by the contraction of the visual field has enabled medicine to make great progress. It has successively brought about the discovery of a crowd of unknown hysterical symptoms, of special spasms, tremors, localized pains, etc. Must it continue to dominate in medicine and must anesthesia be made an essential symptom? The discussion on this point began at the very outset of the teaching of Charcot; his adversaries — and they were numerous — always opposed his interpretation of this symptom. The great and interminable quarrel about traumatic neuroses, which began especially in Germany in connection with railway accidents, rests on this question. This criticism is in great part justified, for hysterical anesthesia certainly does not play in practice the absolutely preponderant role that Charcot maintained it did.

First of all, it is only too certain that this anesthesia is not so easy to recognize as was believed. It has, as we have seen, very delicate psychological characteristics, which make the answers of the subject very often difficult to interpret. But, above all, it is very mobile, very impressionable. Now, your examination alone will suffice to cause a real anesthesia to disappear; now — and this is more serious — your manner of interrogating

will create outright an anesthesia that did not exist. The study of the stigmata is made on no patients so well as on old ones, real pillars of the hospital, who have already been examined thousands of times. When you have to deal with new patients, who have not yet been touched, you recognize with astonishment that anesthesia is rarer, less important than Charcot said. On this point I apologize myself, and acknowledge that, under the influence of la Salpetriere, I formerly attributed more importance to anesthesia than I would do now.

What then must be our conclusion as to the role of anesthesia as a stigma? We should understand one another and not ask the sciences of observation, which are so difficult, to furnish us with absolute theorems. In my opinion, the two meanings of the word "stigma" should be separated. In the first place, it has a theoretical meaning, it indicates the fundamental character, the causal character from which the rest of the disease springs. For instance, if you consider a tuberculous lesion, the real stigma will be the bacillus of Koch, because we consider it, at least at the present day, as the cause of all the innumerable lesions, however varied they are. It will be the same with the existence of the pale spirochæte of Schaudin in syphilis, if the hypothesis is corroborated. Now, we must own that anesthesia does not play this role in hysteria, that we do not know the microbe of that malady, that there is probably none, and that we know no better its histological lesion. From this standpoint, Charcot's stigma has failed.

But the stigma has another meaning, which is practical. It is a mere means of diagnosis. Now, anesthesia accompanies two-thirds of the hysterical accidents. It has, besides, the character of persisting long after the disappearance of the accident. The result is that almost all the hystericals who, at present, show a serious phenomenon, have had in the past one of those accidents that leave behind them, as a trace, some persisting anesthesia. I examine in a subject a perplexing mental or sensorial disturbance, and find traces of a hemianesthesia. It means that, in the course of his life, he has already had, in a greater or smaller degree, a hysterical hemiplegy. I establish with him a contraction of the visual field which he did not even know; it proves to me that he has had in a greater or smaller degree a hysterical amaurosis. Is not this recognition extremely important for the interpretation of the present accident, even if I do not believe at all that this anesthesia accounts for his accident? Very often, in medicine, the stigmata are not so serious as the bacillus of Koch. You examine a patient who has serious intestinal disturbances and fever; you seek on his breast for the little rosy lenticular spots, and, if you find them, you say: "It is typhoid fever." Yet you do not know the role of those spots in the evolution of typhoid fever.

I think, therefore, that the anesthesia of Charcot must remain in practice a very important stigma, the search for which is in the first rank of the methods of diagnosis, but that it is not the only or fundamental symptom of hysteria. There are some troubles and symptoms which we connect with hysteria, though we do not

recognize any anesthesia. We must look more deeply for other phenomena playing the role of stigmata.

II

Anesthesia pleased the physicians, because this symptom is in some manner intermediate between physical and moral phenomena. They could not make up their minds to make hysteria a purely mental malady. They always declared that such was the case, but, in reality, they quickly forgot that declaration to consider by preference physical symptoms and measure them through physical methods. Since hysteria has become a more distinctly mental malady, it is in the mind that we must seek for the stigmata and that we have a chance to find more general stigmata co-existing with all the accidents.

Scientists had long felt that there was a hysterical mental state; you know that it was the fashion to write theses on the character of hystericals. There were first brought into relief in the works of Legrand du Saulle, Ballet, Mœbius, Tardieu, Richet, etc., certain curious and striking, but of course somewhat exceptional, features. Our poor patients were not lucky. Formerly, they were burnt as witches; then, they were accused of all possible debaucheries; then, when the manners had become gentler, one was content with saying that they were versatile to excess, remarkable for their spirit of duplicity, of falsehood, of *perpetual simulation*. "A common feature characterizes them," says Tardieu; "namely, instinctive simulation, the in-

veterate and incessant need of unceasingly lying, without reason, solely for the sake of lying, and this not only in words, but also in action, by a kind of parade in which the imagination plays the principal part, gives birth to the most inconceivable incidents and sometimes proceeds to the most disastrous extremities." So falsehood becomes the stigma of hysteria.

Do not smile; there are still many physicians who take that seriously. No doubt falsehood exists in hysteria; and often it is even very amusing. I regretted very much, when we studied mental disturbances, not having the time to devote a lecture to the accidents of falsehood. I have known two or three subjects, one especially, who were really magnificent. This poor woman has had all her life — that is, for thirty years — an extravagant need of falsehood, above all, of falsehood by letters. Her greatest happiness consists in devising amorous correspondence; she sends to an individual, man or woman, marvellous letters in which she states that he or she has inspired her with a sudden love when passing on the promenade. What is most wonderful is that it always takes. The gentleman answers *poste restante*, and she goes on with the correspondence for months or years. What is sad is that it ended before the assizes; but the observation deserves to be published.

Falsehood is, in my opinion, one of the mental accidents of the neurosis, one of the deliriums that the hysterical may have in a very serious or in an attenuated degree, just as she may have somnambulisms or fugues; that is to say, ambulatory fits. But it is very well known

that all hystericals have not necessarily made fugues. Likewise they have not necessarily all of them the mental accident of falsehood. Its frequency has been much exaggerated. It has been so often described that, in the end, patients were trained to present it. Formerly, Legrand du Saulle was convinced that all hystericals had red flowers in their hair and red ribbons tied to their bedsteads; at length he made them believe it. We cannot dwell on these first mental stigmata, which only show the importance that must be attached to psychological disturbances.

In reality, the great mental stigma that modern studies have brought into evidence is the mental phenomenon of *suggestion*. No doubt I begin to think that the importance given to it, in particular in the last works of Babinski, is somewhat exaggerated, but it is certain that this exaggeration is as yet very slight, and that suggestion is indeed one of the most fundamental stigmata of the hysterical state. But it is necessary to define this phenomenon exactly, to give a distinct meaning to the word, because physicians are in the habit of using it in an extremely vague manner, of comprising under this word all possible mental phenomena.

It is needless to recall the fundamental phenomena of suggestion; you know them very well. You cause any idea whatever to penetrate into the mind of the subject through any means you please, through sensations, signs, and especially speech. Note this fact: there must be an idea. The subject must have the thought, the conception of something precise. This

idea does not seem to conduct itself in him as it usually does in normal minds.

When somebody puts an idea into our head, this idea brings in its train, it is true, other thoughts which revolve around it, some more or less vague images, some gestures, or some incipient movement. If you speak to me of the falls of the Niagara, I cannot help seeing dimly, in a kind of penumbra, a few fragments of that fine scenery. If I am surrounded with calm, I shall be able to dwell a little on that remembrance and to call to mind a few particulars of my journey. The images I see are always dim, and the words I speak, I speak to myself. I always know very well that I am not actually before the falls, and in reality, I do not see them. If you speak to me of dancing, of balls, of rhythmical music, the idea awakens in me, even to this day, an inclination to move my legs, feelings of rhythms. I may even go so far as to move my feet in cadence. But don't be afraid, nobody in a drawing-room will be aware of it, for the movement is very slight and is perceptible only to myself. It is thus that things happen when ideas are called up in our minds.

It is quite different with really suggestible individuals. The idea seems to be transformed and to become at once another psychological phenomenon, an act or a perception. In fact, they almost immediately move their limbs in a manner quite visible outwardly. They really get up and dance; they walk, run, jump, struggle, cry. Instead of confining themselves to thinking the object, they seem to see it in reality or to hear it. They conduct themselves before our eyes like individuals who

have perceptions and not ideas; they reply to imaginary words; their facial expression is that of a person who hears. If we question them, they tell us without hesitation that they see Niagara before them, and the spectacle has so much intensity that it seems completely to efface the normal vision of the things that surround them.

Other ideas become connected with the first, still with the same intensity and the same transformation into actions and perceptions. They seem to make a complete journey; they go along the edge of the falls, over the bridge, down the ravines; they receive the water in their face, etc. All these ideas grouped together form a very close association in their mind, and it will henceforth suffice to call up one to give birth to all the others. It is no longer necessary to say the word "Niagara." A mere vague noise brings about the whole dream. These associations are very important in suggestions, for they determine particular reactions of the subjects to such or such excitation. Thus such a subject may have acquired the habit of convulsions or contractures of the limbs when he sees an electric apparatus or is touched with a magnet. These patients have shakes in their muscles as soon as you put the electrodes of the apparatus on their arms, even if the current does not pass through. Others will experience burns or refrigerations or will feel relieved when they see gold, silver, or iron plates applied to their limbs. It is that which has caused so many gross medical mistakes. Alas, what is left of the big books on the action of metallic plates, of resin plates, on the action of a

breath, indicated by M. Dumontpallier, on the action of passes of the hands turned pointwise towards the subject?

Another important characteristic of suggestion will manifest itself in the visceral domain. No doubt certain ideas awaken also in us certain visceral sensations, a slight nausea, or vesical sensations, but all that is very slight, just like the feeling of dancing. An essential trait of those patients, it was said, is that they make their thoughts penetrate into their viscera. The idea of vomiting brings about real vomiting, an imaginary purge with pure water brings about a real diarrhœa; the menses are stopped or restored with pills of *mica panis*. This is again a very essential phenomenon, for it seems to come close to the real accidents which are to be observed with patients in many circumstances.

We may generalize the essential phenomena that take place in these different cases. The idea is always, as we have already remarked with regard to somnambulisms, a system of images, each of which has different muscular or visceral properties (see the figure 1 in the first lecture). With the normal man, these systems, which are always very numerous, stop one another and do not develop. In suggestion, each idea seems to develop to the maximum, to give all it contains in the way of images, muscular movements, and visceral phenomena. This *complete development* of all the elements contained in an idea is an essential characteristic of the phenomenon.

But, you may say, this development can also be sometimes effected with us. A painter, a novelist, develops

his ideas, seeks for all their elements, renders them as living as possible. It is what all of us do when we try to perform some work, for then the idea brings about material movements of our limbs. The thought of looking for a book causes me really to look for it. This is quite true, but, in all these cases, the development only takes place through a particular mechanism. An accessory force is added to the idea by the will; namely, attention, personality. These words represent an ensemble of very powerful tendencies, which are formed in us by all our past, and these tendencies are added to the idea, too weak by itself, to make it grow. You know the trouble, the voluntary and conscious effort that the development of his idea costs an artist.

In suggestion you meet with nothing of the kind. There is no effort on the part of the subject, no addition of strength from his anterior tendencies, no work of his personality. On the contrary, he does not seem to realize the development of what takes place within him. As has often been recognized, he forgets his suggestions as soon as they are ended. He seems to be very little conscious of them while they are being executed. Very often he executes them without knowing it, quite subconsciously. In this connection, it is very important to remark that not all the phenomena executed by subjects of this kind are suggestions. They may, like normal individuals, act out of compliance with our desire, add to the idea the force given them by the wish to obey, to ingratiate themselves with us, by a regard to their interest or the fear of punishment. One should not say that a hospital patient, whom one frightens and be-

wilders, and who hastens to execute any foolish act in order not to displease the physician, is an individual beset with a suggestion. In order that there may be suggestion, it is precisely necessary that all these normal causes of development should be wanting, and that *the idea should seem to develop to the extreme, without any participation of the will or of the personal consciousness of the subject.*

Bear this definition in mind; many authors, who launched too precipitately into these psychological studies, considered themselves satisfied when they had merely remarked the moral character of the phenomenon. They said that suggestion is an idea that penetrates into the mind of the subject, and stops there. This is childish. As I have so often tried to show, any idea entering into the mind is not a suggestion. We recognize the fact ourselves. If we show astonishment at the phenomenon of suggestion, it is because we think it offers something abnormal and exceptional. The subjects themselves notice it. Their minds are not filled all day long with suggestions. They know very well how to distinguish what is suggestion in them from what is not. A patient has sometimes answered me in a vulgar but quite characteristic way: "Sir, I do not know the reason, but the thing did not take."

"What do you mean? You did not understand what I said?"

"Yes, I understood quite well."

"Then you do not wish to do that, you do not accept?"

"I accept all you please. I am quite ready to obey you, and I will do it if you choose; only I tell you

beforehand that the thing did not take." With the preceding definition of suggestion, these answers of the patient would have no meaning. The idea, having penetrated into the mind and having been accepted, should be accounted a suggestion. Yet the patient was right; she has experienced suggestions, she knows what they are, and, although she accepted the new idea willingly, and with absolute confidence and obedience, yet she felt that things were not proceeding in the same way, and that it was not a suggestion. One should not fall into this exaggeration and take away from the word "suggestion" all precision of meaning. As the ordinary psychological terms, memory, association of ideas, belief, resolution, designate distinct facts, so the word "suggestion" must also designate a very special fact, the complete development of an idea which takes place without the will and the personal perception of the subject.

III

Now that you have formed a precise idea of suggestion and are not likely to confound it with any other psychological phenomenon, you will readily accept an inevitable consequence of this first remark; namely, that suggestion is no longer a commonplace and constant phenomenon. It presents itself only in certain cases and under certain conditions which it is necessary to determine. Suggestion appears to us to present two great characteristics: First, it is a complete development; second, it is a development independent of certain ideas. Both characteristics require certain conditions.

It is necessary, in the first place, in order that an idea shall develop itself, that the innumerable images of which it is composed be awakened and arrange themselves in a series in a proper manner. This is not an unimportant condition, though it is not always met. Certain minds no longer retain images of their sensations and, above all, they no longer keep up the systematization of these images. They are incapable of calling them up and arranging them in a series. They are therefore not suggestible subjects. The type of such individuals will, from the first, come under the name dementia. It is quite plain that with an insane person the images are no longer systematized, and that, consequently, the ideas are no longer either understood or developed. Much hope has been cherished for the therapeutics of insanity through suggestion; we are afraid this operation can be applied only to very special cases. Suggestion requires, in order to be developed, a mind relatively sane. The first condition of suggestion is a certain strength of mind, and some patients are not suggestible because they are, so to say, below suggestion, like some infected patients who are incapable of having fever.

But ought we immediately to pass to the other extreme of opinion and maintain that suggestion is compatible with a mind normally healthy, and that it is continually met in the sanest persons? This is an opinion which appears to us equally unsound.

Despite the affirmations of certain authors, we must confess that we have not succeeded in giving suggestions to people of normal good health. It is useless to discuss the sense of the word "health," and to pretend that ideal

health does not exist. It were repeating the sophism of the Greeks regarding the bald-headed man. We speak of men generally considered normal, without pathological or hereditary antecedents or personal blemishes in a neuropathic sense, without actual defects medically appreciable. If we take a person of that kind (a kind that is numerous, we must confess), and if we state to him that there is a little dog at the corner of the table where he is sitting, he will laugh in our face and experience no hallucination whatsoever.

This fact appears to us incontestable, and to speak of suggestion with sane persons, one is obliged to consider quite different facts, effects of education, habits, recollections, beliefs, etc. They are psychological phenomena which are apparently akin to suggestion, but the mechanism of which is very different. These facts have only gradually become automatic, thanks to the patient's consent. These acts, even to-day, are accepted by the individual who is aware of them and assimilates them with his personality. The result is that such actions are not aggressive; they are limited in their development by other thoughts with which they are brought into relation. Docile, obedient persons, disposed to think of others as having more intelligence and experience than themselves, and, on account of this, apt to believe what they are taught, are not suggestible persons. This complete automatic development of the personality, in the fashion of a parasite, is not met with in the normal mind.

On the other hand, every time that we have established in a person unmistakable suggestibility, we have

had no difficulty in demonstrating numerous and evident traces of mental disease more or less grave, such as excessive absence of mind, or even properly called anesthesias, attacks, paralyses, fixed ideas. We find in the past of such persons all sorts of neuropathic accidents, and the simple fact that suggestibility is still persistent nowadays should impose great reserve on the physician in regard to prognosticating their future. Suggestibility with them should in fact not be considered a simple exaggeration of docility and normal belief. Such persons are oftener neither docile nor believing. They have an unsteady, undisciplined disposition; they themselves recognize that they do not succeed in believing. "I have no more confidence in anybody; I have no confidence at all in you," they often say to me; and yet you can make them see through hallucinations all you wish. They are incapable of voluntary obedience, which demands strength of mind, and they undergo in a sickly sort of way all automatic impulsion.

Thus we have admitted that suggestion cannot develop in sickly minds, that it demands, in order to attain to its full power, minds relatively sane. But we have just now demonstrated that it depends on *a lack of synthesis*, on a weakening of consciousness. Are not these two affirmations contradictory? A symptom may disappear in certain maladies and still remain a pathological symptom. The same with suggestion: it does not belong to all mental disorders, but it is the sign of a particular mental disease. It is necessary for its occurrence that the automatic association of the psychological elements be preserved, and that the actual

synthesis of the phenomena be altered or reduced. It requires as its essential condition a malady of the personality.

It must be confessed that there is a particular disease which unites in a wonderful manner the two essential conditions of suggestion, which are the preservation of automatism and the diminution of personal synthesis; this is the hysterical state. The study of all the accidents has constantly shown us these two characteristics in hysteria. A tendency to suggestion and subconscious acts is the sign of mental disease, but it is, above all, the sign of hysteria.

Let us take another point of view, and consider all the patients we clinically regarded as hysterical. I say that you will almost always find again in them, without difficulty, all the phenomena of suggestion. First of all you will find them experimentally. If you set aside the old quarrels and examine calmly all the subjects who have been presented as fine examples of suggestion, you will first see that most of them are somnambulists. Do not forget, in fact, that it is in the hypnotic state that suggestion was first described. Now, the hypnotic state is nothing but the reproduction of a hysterical somnambulism, and, I do not hesitate to add, in a hysterical subject. Next, it has been shown that suggestion exists in the waking state with these same subjects, susceptible of presenting hypnotism. There is no need to demonstrate this diagnosis.

Then, suggestibility has been shown from time to time in individuals who were not and had not yet been hypnotized. Mistrust these observations; you must first

ascertain whether the suggestions indicated were real suggestions, whether the observer, with his preconceived ideas, was not content with some naïve obedience or, alas, with some comedy. But, if the fact is true, and it is sometimes so, examine the individual clinically, and I assure you that you will have no difficulty in recognizing that he is hysterical. For my part, I have never seen a fine suggestible subject who was not clearly hysterical, and, inversely, I have been able to make all the experiments of suggestion on the subjects who, on the other hand, had decided morbid accidents.

Inversely, this relation between suggestibility and the hysterical neurosis can be verified in the clearest manner by studying the disappearance of suggestion. In fact, as suggestion does not exist with everybody, so you must not fancy that it constantly exists during all the life of the hysterical. There are many circumstances in which the suggestibility of hysteria tends to disappear. What is most interesting in this connection is that it disappears completely when the disease is cured. A great number of those persons, after having kept for some time both the accidents and the mental dispositions that characterize this neurosis, recover completely. Well, at that moment, suggestions no longer take, and these subjects bear themselves in regard to suggestions like normal individuals. This is a very important fact, which I have already pointed out in connection with hypnotism. I have described it these twenty years, and the theoreticians, who will absolutely find hypnotism and suggestion in everybody, have never replied a word to this argument.

Besides, there are other circumstances in which the hysterical recovers, at least partially, for it is a very changeable malady. In certain periods of rest, of health, in certain somnambulisms, or in that which has been wrongly called the second state of Felida, we have seen that the hysterical states disappear. You will likewise recognize that the suggestibility disappears. This symptom only reappears in a state of depression, together with all the other accidents. I described, long ago, those women who are suggestible only three days a month, during their menstrual period. Experimental suggestion has never existed with any persons but with hystericals.

By the side of this experiment you may place real non-experimental suggestions, which occur accidentally and are often the cause of accidents. I mean those accidents with which the patients are inspired by the events of their lives, and which, by developing themselves to an exaggerated degree, bring about attacks, paralytic accidents, or singular visceral diseases. Malebranche related in the seventeenth century the story of a woman who, because she had seen a rider dragged by the foot, had a disease and a paralysis in her foot. We continually see facts of this kind nowadays. One patient has an amaurosis in her left eye because she has seen a child with scabs on its left eye, and another vomits incessantly because he has nursed a cancer of the stomach. In all these cases, if you examine the evolution of the disease, its symptoms, the accidents that preceded it, I do not hesitate to assure you that you will always find again the same neurosis.

In a word, my opinion on this point has become more and more definite. Suggestion is a precise and relatively rare phenomenon; it presents itself experimentally or accidentally only with hystericals, and, inversely, all hystericals, when we study them from this standpoint, present this same phenomenon in a higher or lower degree. If we add that, as we shall see later, this psychological fact plays a great role in the formation of their disease, we may say that the most important mental stigma of hysteria is *suggestibility*. We have still to ask ourselves whether there are not other mental stigmata to be added to this one.

LECTURE XIV

THE HYSTERICAL STIGMATA — THE RETRACTION OF THE FIELD OF CONSCIOUSNESS — THE COMMON STIGMATA

Other proper hysterical stigmata — Absent-mindedness — The contraction of voluntary movements — Subconsciousness — Transfers and equivalences — Alternation — The elementary phenomena of consciousness — Personal perception — Conscious synthesis — The field of consciousness — Its variations — The retraction of the field of consciousness — The common stigmata — The feelings of incompleteness — The need of excitation — The need of attracting attention — Lapses of the mental functions — The weakness of attention — Emotional disturbances — Troubles of the will — The incapacity of beginning or of stopping — The lowering of the mental level

THE role played by suggestion in hysteria is beginning to be known, and I shall no longer raise too many protestations by presenting to you suggestion as a hysterical stigma; but I think it is well to go farther. We should not explain the whole of this so complex disease by this single phenomenon. For the present, I confine myself to remarking that, in the mental dispositions of these patients, there are to be found other facts of at least equal importance. These other fundamental phenomena are also stigmata to my mind. Only I propose to you to divide them into two classes.

Among these *stigmata*, some deserve to be called *proper;* they have the same properties as suggestion itself. They are phenomena that exist in hysteria, but scarcely exist in any other disease. The others might be called *common stigmata*, for the following reason. No doubt, they present themselves among hystericals, and often in a high degree, but they do not exist solely among these patients, and they are to be found in other mental affections, in particular in the psychasthenic neuroses, which are closely akin to hysteria, though different from it. Let us dwell on the other stigmata proper, which are added to suggestion, and devote a few words to the common stigmata, which allow us to connect the neurosis we consider with the other disturbances of the mind.

I

Suggestion, let us not forget, is the development of an idea; it implies a positive phenomenon, the presence of an idea in the mind of the subject. We cannot connect with suggestion things that take place without the subject's being at all aware of them, without his realizing them either consciously or subconsciously. Now, I do not believe that everything in hysteria is in relation with the thought of the subject. There are in these patients attitudes, dispositions that not only are not intentional but that are in relation with no thought of the patients.

I should like to put in the first rank of these phenomena a very singular disposition of mind, for which we have not even a very clear expression; namely, a dis-

position to indifference, to abstraction, to quite *exaggerated absent-mindedness*. The fact is this: while paying attention to something, we turn from some other thing and cease to interest ourselves in other phenomena, which however reach our minds. While I am paying attention to what I am reading, I abstract myself from the noises in the street, though I still perceive them. This abstraction exists in hysteria in an astonishing degree. It was noticed early that it presents itself in regard to the sensations and to ideas. These patients appear to see but one thing at a time, and you become aware that they have no notion of another object, though it be very near the first. When they speak to one person, they forget that there are others in the room. They forget them so entirely that they would tell all their secrets before them with indifference. When they express some idea, you notice that their conviction is childish. It seems very strong because it rests on an astonishing ignorance. Objections, impossibilities, contradictions, do not reach their minds in the least.

The same limitation was observed in their movements from the first. They can perform but one action at a time. The first indication you perceive of a mental disturbance with many girls is their incapacity to do, in spite of their good-will, more than one errand at a time. This fact may even be made in some sort experimental. Here is an experiment that I have described under many forms[1] and that M. Pick, of Prague,

[1] "L'Automatisme Psychologique," 1889, p. 188 *et seq.* "The Mental State of Hystericals," English translation, p. 161.

has developed.[1] You ask one of these patients to make a certain movement continually, for instance to make on the table with her right hand the movement of playing on the piano. It is agreed that she must not discontinue this little movement, whatever may happen. At the same time, you ask her to perform some other simple acts, to open her mouth, to shut her mouth, to recite numbers. You always remark that the first movement, the piano playing, stops as soon as the second begins, and that it only recommences at the end of this second movement. Yet the subject had made up her mind to continue this movement, she had this idea in her head, but it became impossible for her as soon as she tried to do something else.

It is this, besides, that gives a special appearance to all their accidents. By the side of the positive phenomenon, consisting in the development of the somnambulic idea, in convulsions, in persistent emotions, there was a kind of lacuna, a complete oblivion of the present situation, an indifference to ridicule, an insensibility to fatigue, all of which we should not have had in their place. One would think that these subjects, when once ill, forget all that is outside their present accident. They do not remember having been in another state, they do not conceive that one can be in another state. Hence that resignation, that absence of effort, which surprised us.

The exaggeration of this disposition will bring about the phenomenon of *subconsciousness:* a great many

[1] A. Pick, "Ueber die Sogenannte 'Conscience Musculaire,'" *Zeitschrift fur Physiologie der Sinnesorgane*, IV, 1892.

things will exist outside the personal consciousness. You will be able to make the patients walk and act unknown to themselves. If the ideas you express do not attract their attention and if they remain in that domain of absent-mindedness, it will result in mediumship, as we saw before that the development of the ideas results in great somnambulisms.

Can we say that this disposition to exaggerated absent-mindedness is a consequence of the preceding symptom of suggestion? In fact, it is not so, for absent-mindedness is not suggested to these patients and often is not even noticed. They have not the idea of this phenomenon, the importance of which they do not suspect. This singular absent-mindedness is mostly noticed by those around them, or by themselves only very late, several years after it has begun to develop itself. On the other hand, it is difficult to understand how suggestion, which is precisely the development of an idea, could explain this absent-mindedness, which is indifference to an idea, a tendency to suppression. Lastly, suggestion itself appears to me to depend on that disposition, and to be much oftener its effect than its cause. It is precisely because the subjects have forgotten everything, because they are no longer restrained by any sensation, by any thought relative to the reality that surrounds them, that they allow the ideas suggested to them to develop freely. Suggestion and absent-mindedness do not produce each other, they are two parallel stigmata, one of which cannot exist without the other.

This special absent-mindedness is a stigma peculiar

to hysteria. First of all, you do not find it in the normal individual. Normal consciousness, as philosophers say, is always a fully illuminated point, surrounded by a strong penumbra. With the hysterical, the penumbra is wanting. This fact is brought into evidence by their quite peculiar visual field; you do not find in any normal individual that odd vision, which sees very clearly in one point and sees nothing around this point. Nor is this absent-mindedness to be met with in the same fashion in the other maladies of the mind. Individuals who are tired are inattentive, but their minds are vaguely on the stretch. No doubt, they search into nothing, but they have a vague notion of everything. Their sensibility is attenuated, I grant, but it is distributed over the whole of their body. Their vision is diminished, but their visual field remains broad. In a word, the symptom I wish to describe to you is not inattention; it is a suppression of all that is not looked at directly, and I do not believe that it is to be found in this form in the other diseases of the mind. So I make it a stigma proper to hysteria as suggestion itself.

A third phenomenon, which, besides, depends on the preceding ones, will make you understand these strange stigmata still better. It is the phenomenon of *transfers* and *equivalences*. I was seeking one day to cure a small localized accident, to restore the motion of the right wrist with a patient whose fist was contractured. You know that, to succeed, one must strongly direct the attention of the subject to the diseased organ, which she has forgotten, determine sensations in it, move it passively in every way; then, when the motion has

been a little restored, induce the subject voluntarily to move this wrist. This work is long and troublesome, and has to be begun over and over again with hystericals. When it has proceeded for some time, the result seemed marvellous; the right hand had opened and moved freely in every way, the patient left the laboratory very happy and proud. She reentered it a few moments later in despair. "It was not worth while making such efforts," she said, presenting her left fist, which was contractured exactly in the same way as her right fist had been a few minutes before. I have cited this adventure because it struck me by the circumstances in which it occurred; namely, in a quite naïve patient, having no notion of the phenomenon, and without the operator or herself having had the least idea of it, beforehand.

You know that the result is not always like that. During a certain period, from 1875 to 1890, this phenomenon, which is called transfer, was very much sought after and often provoked artificially. It was said to be brought about by the mechanical action of certain substances. Thus the magnet had preeminently the power of provoking transfers. To cure a paralysis of the right side, a big magnet was placed in the bed of the patient, near her right side. The paralysis was then found to disappear on that side and to become localized on the left side. When the magnet was withdrawn, the paralysis reappeared on the right side, and, after several oscillations of this kind, it vanished. Other substances — metals in particular, sometimes the electric current — had similar effects, and transferred

symmetrically from one side to the other the disturbances of sensibility as well as those of motion. You remember that this phenomenon was very much studied by Burcq and Dumontpallier, who ascribed to it very odd laws. Some physicians said they had found the means to make the oscillations either slow or rapid, to fix the disturbance on one side or the other, etc. Others went even further; they invented the change of the colour sensations, which were transformed into their complementary colours. The patients, after having seen red, saw green; after having seen yellow, they saw violet. They called this polarization, and, by means of the magnet, tried to polarize also the feelings. Lastly, — for absurdity has no limits, — they tried to transfer a phenomenon from one subject to the other; they placed two subjects back to back, and, thanks to the magnet, the paralysis of the first passed into the second, and, after a few oscillations, disappeared. It became a convenient therapeutic process.

No doubt there are in all this many childish errors. Many of these observations are phenomena of suggestion and training, they depend on the direction that is given to the attention of the subject. This could not but be gradually recognized, so that, in science as in politics, we saw a violent reaction. The very notion of the phenomenon of transfer was suppressed, and the fact that there is some little truth in it was overlooked. In my opinion, this passage of an accident from one side to the other is not necessarily the result of a suggestion. It sometimes takes place unknown to the subject and to the operator, and that very naturally.

It is a particular application of a disposition which is very general with the hysterical, and of which a thousand other applications are to be observed; namely, the disposition to *equivalences*. Hysteria, in fact, is a very singular malady, the cure of which one never dares assert. It is often easy, through some psychological process or other, to cause such or such a determinate accident to disappear. Besides, these accidents often disappear of themselves, in consequence of an emotion, of some shake, or even without reason. But, when an accident has disappeared, especially when it has disappeared too quickly, we should not at once cry out victory. First of all, the same accident is very likely to soon reappear. Then the following strange thing very frequently occurs: another apparently quite different accident takes the place of the first. A girl of twelve presented incoercible vomitings, which had brought her to a very serious state of inanition. Thanks to certain excitations of the sensibility during a somnambulic state, I succeed in making her eat with more sensibility, in regularizing her deglutitions, and she no longer vomits. This seems all right, but, from that moment, this girl, till then perfectly intelligent, enters into a state of mental confusion and delirium, and it becomes impossible to stop this delirium without the vomitings beginning again. Let us remark by the way that this singular alternation between disturbances of the stomach and deliriums is one of those that are oftenest observed. I have noted down five fine examples of them.

But other identical facts are to be observed. One

patient has contractures in her limbs, and, when the contractures disappear, mental disturbances; another has hysterical coughing, and, alternating with it, crises of sleep. A man had a foot contractured in the position called varus. He was cured through somewhat mysterious processes, which frightened him. He could now walk freely, but he lost his voice for three months. When his voice returned, he had gastric accidents and abdominal contractures. In another case, the contractures of the trunk were healed and replaced by phenomena of amaurosis. And so on indefinitely. The accidents seem to be equivalent and to have the property of bearing on one side or the other, provided they exist somewhere. You would think that the subject can choose but cannot do without a disturbance localized in some place or other. If you understand this law of equivalences well, you will see that the transfer from the right side to the left side is but a particular case of it. It is even a particularly simple form of equivalence, for the sensations of the symmetrical parts are very similar and can very easily be replaced by one another.

No doubt, in many diseases of the mind, we observe instability, but this quite special form of instability which replaces one definite accident by another apparently quite different, and that suddenly and clearly, is, again, very characteristic. I think it results from a general disposition of the hysterical mind, which urges it to move in its entirety to one side, while neglecting the rest of the body and mind, then to move in its ensemble in another direction, while forgetting the first. This

is connected with the preceding phenomenon of suggestion, and constitutes the last of the stigmata peculiar to hysteria that I wished to point out to you.

II

Can we summarize these three stigmata, suggestion, absent-mindedness, and alternation, into a single general idea that will enable us to conceive the essential character which manifests itself in these mental troubles? I proposed formerly to characterize this mental state by an expression that is perhaps singular, but that may be serviceable. You will find it in my work on the psychological automatics in 1889 and in my book on "The Mental State of Hystericals," 1894, which was very well translated into English by Mrs. C. Rollin Corson in 1901. I proposed to summarize this somewhat peculiar mental state by the words "*retraction of the field of consciousness.*" Let us try to understand the meaning of this general expression.

The word "consciousness," which we use continually in studies on the mental state of our patients, is an extremely vague word, which means many different things. When we use it in particular to designate the knowledge the subject has of himself, of his sensations and acts, it means a rather complicated psychological operation, and not an elementary and irreducible operation, as is generally believed. If I say, for instance, "I feel a pain, I feel that I move my arm," there take place in my mind rather complicated phenomena, which we can analyze in the following manner. In the first place,

there occurs somewhere in my brain, on the occasion of an outer excitation, a small fact, both physiological and psychological, which corresponds to a phenomenon of pain, to an elementary sensation of motion. The great physiologist Herzen said that the brain may be compared to a spacious hall filled with innumerable small electric lamps. From time to time, certain little

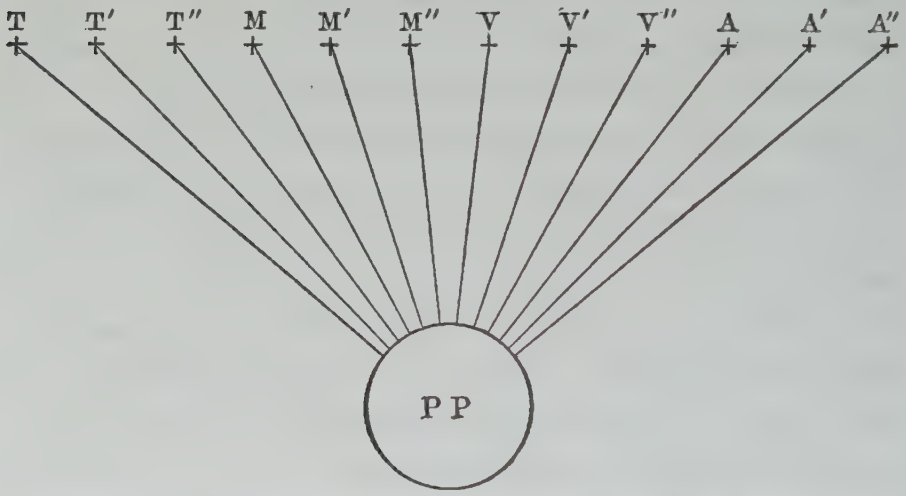


FIG. 21. — *T T′ T″*, elementary sensations of touch; *M M′ M″*, of muscular sense; *V V′ V″*, of vision; *A A′ A″*, of audition; *P P*, personal perception.

lamps kindle here and there. This is what is designated by the isolated words, "sensation of pain," "sensation of vision," "sensation of motion." In the scheme I have drawn (Figure 21), each separate little cross of the upper line designates one of those little phenomena, *V*, *V′*, *V″*, when it is a question of the vision, *T*, *T′*, *T″*, when it is a question of the sensations of touch, and so on.

But the complete consciousness which is expressed by the words, "I see, I feel a movement," is not com-

pletely represented by this little elementary phenomenon. It contains a new term, the word "I," which designates something very complicated. The question here is of the idea of personality, of my whole person; it is the union of present sensations different from the little sensation considered, from all past impressions, from the imagination of future phenomena. It is the notion of my body, of my capacities, of my name, of my social position, of the part I play in the world; it is an ensemble of moral, political, religious thoughts. It is a world of ideas, the most considerable, perhaps, that we can ever know, for we are far from having made the tour of the domain of personality. There are then in the "I feel," two things in presence of each other: a small, new, psychological fact, a little flame lighting up — "feel" — and an enormous mass of thoughts already constituted into a system — "I." These two things mingle, combine; and to say "I feel" is to say that the already enormous personality has seized upon and absorbed that little, new sensation which has just been produced. If we dared, and it is not altogether absurd, we should say that the "I" is a living animal, extremely voracious, a sort of amœba, which sends out tentacles to seize and absorb a very small creature which has just been born at its side.

After having represented in the first line of our schema the elementary sensations, or affective states, or simply subconscious phenomena, we represent, secondly, a reunion, a synthesis of all these elementary phenomena which are combined among themselves, and particularly combined with the vast and prior

notion of personality. It is only after this sort of assimilation that we can truly say, "I feel." I formerly proposed to designate this new operation by the name of *personal perception*, P.P., for it is indeed a perception, that is to say, a clearer and more complex consciousness. The word "personal" will prevent confounding this operation with the outward perception, of which we do not treat here, and will recall to mind that its essential character is the addition of the notion of personality.

This figure is, of course, quite theoretical, for it supposes an absurd thing; namely, that a man becomes at a given moment conscious of, assimilates to his personality, all the elementary sensations that are born in all his senses. Think what enormous masses of phenomena must spring up in us constantly from all the points of our body, from the crowd of impressions made on our skin, on our mucous membranes, on the organs of our senses, by all the outer and inner phenomena. It is certain that a man never perceives them all. There are always, even in the most normal man, a quantity of impressions that are born in one point of the skin, reach to the brain, determine a few reflexes, awake perhaps a few little states of elementary consciousness, contribute, no doubt, to his general state of well-being or discomfort, but are not clearly perceived by his personality. A part only of these elementary sensations gives rise to complete and personal perception.

What is the number of those elementary phenomena that rise to complete consciousness? Of how many elementary sensations can we simultaneously have the

complete consciousness? This is what I proposed to call the problem of the extent of the field of consciousness, by analogy, as you see, with the extent of the visual field. This problem is not clearly resolved, and psychologists have proposed very different figures.

The only essential and certain thing is that this extent of the field of consciousness varies very much with individuals and their states of mind. An orchestral conductor, hearing simultaneously all the instruments, and following by reading or by memory the score of the opera, unites in each of his states of consciousness an immense number of facts. The individual who, when asleep, dreams, and the patient during a crisis of ecstasy, have, on the contrary, in their conscious thought a very limited number of facts. I think there are on this point perpetual and very nice variations of our mental state.

If you understand this psychological conception well, you can easily apply it to the preceding phenomenon that we have just noted with our hysterical patients. Their first moral stigma, suggestion, already shows us the isolation of the ideal; it is because there is no reaction between the various impressions that each word, each emotion, each remembrance, takes an inordinate development which we called suggestibility. Suggestion, it is always said, depends on the absence of control. But control is nothing but the struggle, the competition of the various psychological states united in the same consciousness. If it is wanting, it is because the mind is too narrow to contain several ideas opposing one another. The second characteristic,

exaggerated absent-mindedness, that abstraction bringing on all the blanks of consciousness, is but another aspect of the same phenomenon.

Our schema gives us the formula perfectly. Let us suppose (Figure 22) an individual who cannot see, at

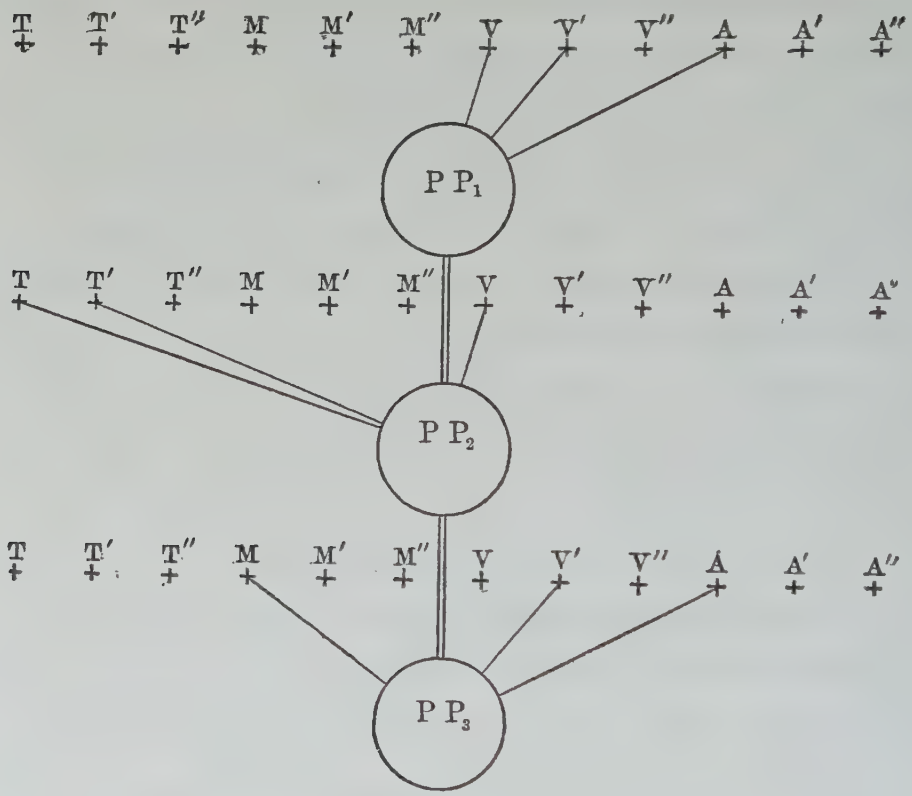


FIG. 22. — Schema of absent-mindedness.

a given moment, more than three elementary sensations, such as V, V', A. He will leave all the rest in his subconsciousness. At another moment, he will be able to turn to T, T', V, or to M, V', A. At the first moment, he will look at, and listen to, a person who speaks to him, without troubling about the tactile sensations which continue to assail him. At the second moment, he will

look at an object while touching it, and appreciate the contact without having consciousness of the surrounding noises. At the third moment, he will write at dictation, having the perception of the sound of the voice, of the vision of the letters and of the muscular movements, but forgetting and neglecting all the other elementary sensations, as T, T', T'', M', M'', V, V'', A', A''. This individual is absent-minded, and this (Figure 22) is an attempt to schematize what is called normal absent-mindedness.

Let us suppose that the field of consciousness becomes still more contracted. The patient can no longer perceive more than two elementary sensations at once. Of necessity too, he reserves this small share of perception for the sensations which seem to him, whether right or wrong, the most important, the sensations of sight and hearing. To have consciousness of what is seen or heard is of paramount necessity, and he neglects to perceive the tactile and muscular sensations, thinking he can do without them (Figure 23). At the outset, he might perhaps still turn to them and take them into his field of personal perception, at least for a moment; but, the chance not presenting itself, the bad psychological habit is slowly formed. Nothing is more serious, more obstinate than these moral habits. There is a crowd of maladies that are only psychological tics. One day the patient (for he has truly become one now) is examined by the physician. The latter pinches his left arm, and asks him if he feels it, and the patient, to his great surprise, is obliged to confess that he can no longer feel consciously. The too long-neg-

lected sensations have escaped his personal perception; he has become anesthetic.

You may easily understand that the same notion of the contraction of the field of consciousness equally

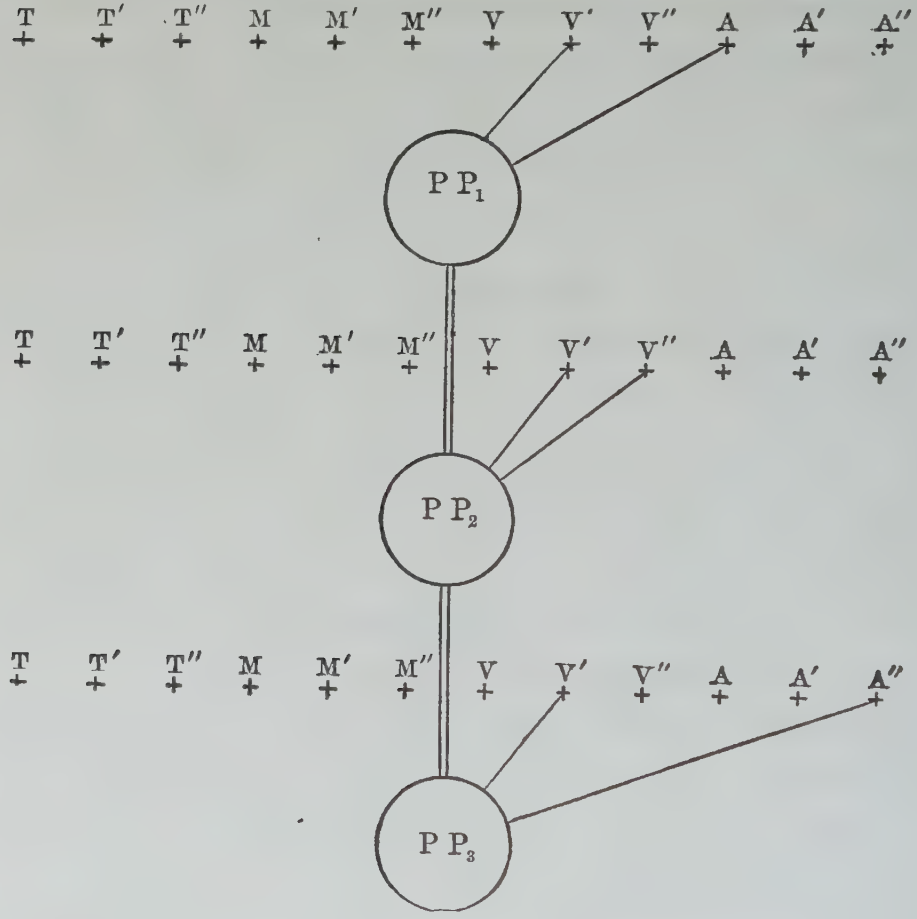


FIG. 23. — Schema of the contraction of the field of consciousness in hysterical anesthesia.

sums up the last phenomenon, that of alternations. It is because the field of consciousness remains contracted, that you can never add one phenomenon on one side without taking one away from another side. If you force the subject, by attracting his attention, to recover

the sensibility of the left side, he loses it on the right side. If you obtain the total tactile sensibility, the reduction of the visual field increases so much that the subject becomes momentarily blind, a thing we have observed a number of times without having foreseen it. If you wish to enlarge the visual field, the tactile anesthesia will increase. The feebleness of these patients' thinking continues, and they lose on one side what they seem to have regained on another.

I am therefore inclined to think that this notion of the retraction of the field of consciousness summarizes the preceding stigmata, and we may say that their fundamental mental state is characterized by a special moral weakness, consisting in the lack of power, on the part of the feeble subject, to gather, to condense his psychological phenomena, and assimilate them to his personality.

III

Formerly I stopped at this point my description of the hysterical mental state, implying that all the other disturbances of their character could be connected with the preceding ones. It no longer seems to me absolutely true to-day. The hysteric malady is not absolutely isolated, like other mental disturbances. It is a special form, which constitutes a part of a much more considerable group, and which is more or less distinguished from the other diseases belonging to this group. The patients we consider are first and above all neuropaths, individuals whose central nervous system is weakened; then they are hystericals, when their en-

feeblement takes a particular form. I even affirm that they are more or less hysterical according as their malady takes a more or less decided turn in this determinate direction. The result is that, besides the properly hysterical stigmata, they have general vague disturbances, at once psychological and physiological, which belong to all neuropathic individuals. We cannot enter into the enumeration of these disturbances, which, besides, would be more interesting in connection with other subjects, but we must indicate them shortly under the title of *common stigmata* which you understand now.

I will point out to you in this connection certain feelings that play a role in the popular conception of hysteria. These subjects feel weak, dissatisfied with themselves; their actions, ideas, feelings, appear to them reduced, covered with a kind of veil. They are, therefore, perpetually tormented by a vague ennui which they cannot overcome. Ennui is the great stigma of all neuropaths. You must not believe that it depends on surroundings; the neuropath feels dull everywhere and always, for no impression any longer brings about with him lively thoughts that make him pleased with himself.

These general sentiments of dissatisfaction, these *sentiments of incompleteness*, as I have christened them elsewhere,[1] almost always give to the patient a peculiar attitude or conduct. Either he is sunk in despondency and exhibits a doleful air, or he seeks everywhere for something that can draw him out of this state. Now he has but very few means at his disposal to rouse himself, to come out of such a painful state. Either

[1] "Obsessions et psychasthenie," 1903, I, p. 264.

he will use physical and moral processes of excitation, walking, jumping, crying, or he will appeal to other persons, and will incessantly ask them to excite him, to revive him through encouragements, through praises, and especially through devotion and love.

You see what will result from these needs. These patients will be, at the same time, plaintive and agitated, they will commit all kinds of eccentricities, because eccentricity excites them and draws attention to them. They must needs attract attention to themselves, in order that people may take an interest in them, speak to them, praise, and, above all, love them. This need of attracting attention, of being praised and loved, is one of the things that have been most remarked. In my opinion it has always been wrongly interpreted.

First of all, it is a clinical error to ascribe this character to hysteria. It sometimes exists in a very high degree with hystericals, but it is by no means a stigma peculiar to this malady; it exists as well in the psychasthenic. The amorous manias of doubters and of patients laboring under obsessions, their mania of jealousy, their need of attracting attention to themselves, are often much stronger and especially more enduring than with hystericals. This remark has very often caused errors of diagnosis.

Besides these feelings of incompleteness, we might enumerate with our hystericals, as with all neurasthenics whatsoever, the innumerable *lapses of all the mental functions.* We note in the intelligence a certain apparent vivacity, associated with a fundamental state of

laziness and especially of *reverie*. These patients pay attention to nothing, can bear no mental work. Hysteria, like all neuroses, begins, among girls, with the cessation of their studies and the complete incapacity of learning anything. In fact, this *incapacity of attention* brings with it, as a consequence, *the absence of memory*. Events are not fixed in the mind. Whereas old remembrances relating to periods previous to the malady are well preserved, and are even reproduced with an exaggerated automatism, recent events pass without leaving any trace. It is a disturbance of the memory, which I have described under the name of *continuous amnesia*.[1] It is frequent with hystericals, but it is not proper to them and it must be considered only as a common stigma.

The same alterations are found in the feelings, which are weakened. The subjects, who seem so *emotional*, in reality feel nothing vividly. They are *indifferent* to all new feelings, and confine themselves to reproducing with an automatic exaggeration a few old feelings, always the same. Their emotions, which seem so violent, are not just; that is to say, they are not *en rapport* with the event that seems to call them up. You always hear the same cries, the same declamations, whether the question is of a surprise or of a happy or an unfortunate event.

Lastly, *the disturbances of their will* are well known. The patients no longer will or rather they can no longer do anything. They can no longer make up their minds to anything, hesitate indefinitely before the least thing.

[1] "Nevroses et Idees fixes," I, p. 109.

I think, even, that they can no longer make up their minds to sleep, and, in many cases, the so serious *insomnia* of neuropaths is a phenomenon of *abulia*, for they cannot even make up their minds whether they will remain awake or asleep. Of course, it is especially new actions that will become difficult and, for a long time, the patients go on with old actions, without being able to stop, before they enter a state in which they no longer do anything.

This *incapacity of beginning* an act or an effort of attention, and this *incapacity of stopping* it when it is once begun, bring about the most serious disturbances. Most of the accidents might easily have been stopped at the outset. We begin to dream because we wish to do so, reverie is so pleasant. We begin to eat sparingly in order to be thin, to have a small waist, and not to look like mamma. We begin an annoyance, get into tantrums, but we were provoked to it. All this, as the patients will themselves confess, might have been very easily stopped at the beginning; but the act continues more and more automatically, and the patient can no longer stop it herself. It becomes a delirium, an anorexia, and an attack. "When I have begun something," we heard a patient say, "I must go on with it; I cannot stop. I would break the windows, kill myself. I fall into an idea as down a precipice, and the declivity is hard to climb again."

No doubt you will find all these phenomena of abulia with all neuropaths. But that is not a reason for neglecting them with hystericals. They constitute with them common stigmata which add themselves to their

proper stigmata, and, besides, often assume a particular aspect under the influence of the latter. It is easy to summarize, in a word, these general disturbances of neuropaths. It is a mental depression characterized by the disappearance of the higher functions of the mind, with the preservation and often with an exaggeration of the lower functions; it is a *lowering of the mental level*. So we may say, in short, that hystericals present to us the following stigmata: a depression, a lowering of the mental level, which takes the special form of a retraction of the field of consciousness.

LECTURE XV

GENERAL DEFINITIONS

Review of the typical symptoms of hysteria — The positive and negative phenomena in somnambulism with amnesia, in agitations with paralyses and anesthesias — The general idea of the contraction of the field of consciousness and of the lowering of the mental level — Definitions of hysteria — Their congruency — Psychological definitions — The need of precision in these definitions — Definitions of hysteria as a disease by suggestion — Discussion of these definitions — Fixed ideas, without relation to the medical form of the accident — The physiological and psychological laws unknown to the patient — The conditions of suggestion — Hysteria as a form of mental depression, characterized by the contraction of the field of personal consciousness and a tendency to the dissociation and emancipation of the system of ideas and functions that constitute personality — The laws of localization — The part played by the difficulty of the function, by psychological automatism, by the anterior weakening of the function, by the localization of the emotion

In these lectures on the great symptoms of hysteria, I have tried to present a rapid picture, not of all the symptoms of hysteria, but of the essential ones, in order that you might form a just idea of a singular malady, of which everybody speaks and which but few physicians know well. I have only presented to you the typical

cases and forms, around which it is easy for you to group the degraded forms and confused aspects which most diseases offer in practice. We must try now to sum up these descriptions and to derive from them some general conception of the whole disease.

I

Allow me, first, to remind you in a few words of the essential pictures you should keep before your eyes in order to form a general idea of the hysterical disease. We have studied somnambulism together. I no longer say "hysterical somnambulism," for there is no more any somnambulism for us, outside of hysteria. We have studied it under its simple and typical form of monoideic somnambulism, then in its more complete forms of fugues, of polyideic somnambulisms, of artificial somnambulisms. You remember that we have always recognized in it the exaggerated development of an idea, of a feeling, of a psychological state, in a word, of a system of thoughts, which takes place outside the memory and the normal consciousness. This dissociation of a psychological system is manifested not only by the preceding development, but also by amnesia, bearing not only on the somnambulic period, but even, in remarkable cases, on the whole of the idea and of the feeling.

When later we studied various accidents bearing on the movements of the limbs, we recognized that small systems of movements, and sometimes great systems, rich and old, constituting real functions, develop themselves without control to an exaggerated degree,

and give rise to tics and choreas of various kinds. This lack of control is manifested through negative phenomena closely connected with the preceding ones, paralyses and anesthesias, which seem to play here the same role as the amnesias of somnambulism. When we came to the sensorial functions, we saw the same agitations under the forms of tics, of pains, and of hallucinations, accompanied with certain losses of control which constitute various anesthesias bearing on the special senses as well as on the general sensibilities.

In connection with these anesthesias, we remarked more clearly than we had done in connection with the preceding phenomena, the real nature of these amnesias, of these paralyses; in a word, of these disappearances of functions. The function is far from being destroyed. It continues to exist and often even develops to an exaggerated degree. It is only suppressed from one very special standpoint; it is no longer at the disposal of the will or the consciousness of the subject. Surprising as it is, we recognized the same facts not only in the complex function of speech, but even in the visceral functions. The refusal to eat, vomitings, hysterical dyspnœas, are not diseases of the stomach or lungs. They consist in a kind of emancipation of the cerebral and psychological function relative to these organs. There is now an exaggeration independent of the function; again and more often, a disappearance from consciousness of these organic wants and of the acts that are connected with them.

Finally, in our last lectures, we sought in the very character of these patients, in the status of their minds,

for fundamental stigmata allowing us to recognize and understand the malady. We succeeded in bringing into evidence, on the one hand, stigmata proper to hysteria: suggestion, absent-mindedness carried to unconsciousness, alternation, which we summarized in the general idea of *retraction of the field of consciousness;* and, on the other hand, general stigmata, the absence of attention, the lack of feeling and of will, which are connected with depression, with the *lowering of the mental level.*

This is a clinical picture that must suffice us in practice. If we remember these chief facts, by comparing with them the complex and less clear cases that practice presents to us, we shall succeed in appreciating the hysterical disease fairly justly while avoiding many prejudices and errors that are still very common nowadays.

Unfortunately, the human mind is not so easily content; it is fond of dangers and quarrels, and we feel the need of formulating concerning hysterical disease general conceptions, interpretations, definitions, which are much more exposed to criticism and error. It seems to me that it is in some way a medical fashion to give definitions on hysteria. Already, in the old book of Brachet, in 1847, there were, at the beginning, about fifty formulas passed in review. Though Lasegue said that hysteria could never be defined and that the attempt should not be made, since that declaration everybody has tried to define it. I have discussed, in my little book on hysteria, about ten definitions, and I have been foolish enough to present a new one. Of course, physicians have continued to define it, and, since

that time, ten others or so have been proposed. We must obey the fashion by saying a few words about these definitions. Let us try to derive from them, without attaching too great importance to the terms, a general idea that suffices us in practice.

II

I am wrong in laughing at the definitions of hysteria and observing to you their abundance, which, in these matters, is not a proof of truth. These definitions have evolved; they have made visible progress, and, though they appear numerous nowadays, they come so close to one another that they blend together. Do not forget that we are speaking of medicine, and that this is rather a special domain, less calm and serene than high mathematics. You should not ask too much of the virtue of a physician, or hope that he will confine himself to repeating the definition of a predecessor, even if he does not cite his name. What would be left for him? He must needs change something in these definitions, were it but a single word, in order to appear to innovate, which, in medicine, is indispensable. I do not exaggerate in telling you that, nowadays, three-fourths of the definitions of hysteria are nearly identical.

Thus, I shall perhaps surprise you by telling you that there is no opposition between the definitions that gloriously entitle themselves physiological and those that modestly call themselves psychological. No doubt, there would be a great difference if these authors had seen, really seen, a lesion characteristic of the neurosis,

and if they had connected the evolution of the disease with this lesion. Never fear, one can make, nowadays, a so-called physiological definition at smaller cost. It is enough to take the most commonplace psychological definitions and replace their terms with words vaguely borrowed from the language of anatomy and the current physiological hypotheses. Instead of saying, "The function of language is separated from the personality," one will proudly say, "The centre of speech has no longer any communication with the higher centres of association." Instead of saying, "The mental synthesis appears to be diminished," one will say, "The higher centre of association is benumbed," and the feat will be done. I recommend to you in this connection to read the last book of M. Jose Ingenieros, published at Buenos Ayres, in 1906. In the first chapter, which I do not understand very well on account of my imperfect knowledge of Spanish, he shows that many of the definitions of modern physicians are equivalent, and I am quite of his opinion. So there is an ensemble of points on which all the authors agree, and it is those which we shall have to bring into evidence.

Charcot used to say that hysteria is an entirely psychic malady. This opinion was discussed at his time. There were still some remainders of the old uterine and genital theories; there were still some attempts to connect hysteria with various nervous lesions. Dr. Bastian's book,[1] in England, a very interesting book, is very courageous. He had the pretension to localize

[1] Charlton Bastian, "Various Forms of Hysterical or Functional Paralysis," 1893.

different hysterical accidents in different corners of the medulla, of the bulb, or of the lower centres of the encephalon. That there is no truth in those old conceptions, that hysteria will not be recognized later as resulting from some unknown disturbance of the secretion of a vascular gland or from some lesion of a nowadays badly defined nervous system, I should not dare assert; but one thing is certain; namely, that for twenty years everybody has departed from this view of the matter, and that the psychological conception has the mastery. I again observe to you that I consider the pretended physiological definitions as mere translations of the psychological ideas. This point is almost agreed on by every one.

But now, difficulties begin. Of what kind of psychological disturbance is it a question? We should not, under pretence of psychology, confusedly link hysteria with the vague group of mental diseases and the old nervosismus. On this point, the work of a distinguished physician, Dr. Dubois, of Bern, interesting from other standpoints, is, in my opinion, absolutely pernicious. The psychological interpretation should not suppress what is good, what is excellent, in our ancestors' works. Now the last century produced a monumental work; namely, clinical work. With infinite patience and penetration, all those great clinicians introduced order into a real chaos; they ranged the diseases in groups, they enabled us to recognize these groups. Improvements should consist in consolidating this edifice and not in throwing it down. To say, under pretence of psychology, that a somnambulism

is identical with any delirium, that hysterical vomiting is a mere derangement to be confounded with manias of doubt or with melancholias, or even, perhaps, with the tics of idiots, is to go two hundred years back, and it would be much better to suppress the psychological interpretation and be content with the clinical description. Consequently, in making hysteria a psychological affection, we do not intend at all, as M. Grasset seemed to believe, to confound it with some sort of other, or mental, malady. We even say that it is nowadays the most characteristic disturbance of all, and that it is important to distinguish it well.

The first psychological notion that appears to me to result with the greatest clearness from all the contemporary works is a notion relative to *the importance of ideas* in certain hysterical accidents. Charcot, studying the paralyses, had shown that the disease is not produced by a real accident, but by the idea of this accident. It is not necessary that the carriage wheel should really have passed over the patient; it is enough if he has the idea that the wheel passed over his legs. This remark is easy to generalize. There are such kinds of fixed ideas in somnambulisms and fugues; the idea of one's mother's death, the idea of visiting tropical countries, etc. There are such ideas in systematic contractures, for instance, when a patient seems to hold her feet stretched because she thinks herself on the cross. There are such ideas in visceral disturbances, and I have shown you the observation of a patient who died of hunger because she had the fixed idea of the turnips she had eaten when at school. These remarks have been

well made on every side. It has also been established that, with hystericals, ideas have a greater importance, and, above all, a greater bodily action than with the normal man. They seem to penetrate more deeply into the organism, and to bring about motor and visceral modifications. It is a point which was again emphasized by MM. Mathieu and Roux, in a recent paper they devoted to hysterical vomiting. "What characterizes hystericals," they said, "is less the fact of accepting some idea or other than the action exercised by this idea on their stomachs or intestines."

At the same time, the studies on suggestion, which have been very numerous, have allowed clinicians to realize experimentally, through the action of ideas, many phenomena analogous to hysterical accidents. So it may be said that the most common conceptions of hysteria turn on this character. Mœbius in 1888, after Charcot, said: "We may consider as hysterical all morbid modifications of the body that are caused by representations." Strumpell, in 1892, Bernheim, Oppenheim, and more recently, Babinski, have repeated each of them, of course with a slight change in the words, quite similar definitions. "A phenomenon is hysterical," said Babinski, "when it can be produced through suggestion and cured through persuasion." Let us take no account of the end of the sentence. The treatment and cure are delicate things; much might be said on those cures through persuasion. Let us only retain the beginning: *hysteria is defined by suggestion.* It is absolutely the conception of Charcot and Mœbius, hysteria through fixed ideas and hysteria through representation. This

word "suggestion," which, besides, one takes care not to define, is taken simply in the sense attached to it by all the preceding authors, namely that of a too-powerful idea acting on the body in an abnormal manner. It is easy to remark here a unity of a great number of contemporary conceptions.

III

I do not object very much to the preceding definitions. If more precision were given to the meaning of the word "suggestion," these definitions would be agreed on by everybody. Besides, these definitions bring back all the accidents of the neurosis to a symptom we have put in the first rank among the stigmata, to the suggestibility. So they are very scientific and useful. It is one of the first results of all the psychological work that has been done on hysteria. However, I had already discussed them in 1894, and still think them insufficient. As my arguments have been very little contradicted, I will try to formulate them more clearly.

In the first place, I believe that this conception of hysteria is more just in theory than in practice. It rather summarizes a systematic interpretation than the clinical observation. It is we who have repeated that the accidents seem to be brought about by ideas. It is not quite exact that we always observe these ideas. In a few cases — and they are always the ones that are repeated — the patient, it is true, has the idea that he is paralyzed. "I thought," he says, "that my leg was crushed; I had the idea that my leg no longer existed."

The consecutive paralysis with anesthesia of the limb seems to be the exact translation of his idea. But it is a singular exaggeration to apply this indifferently to all hysterical accidents, and to say unreservedly with M. Bernheim, "The hysterical realizes his accident just as he conceives it."

This is to come back to a kind of contemptuous accusation against the patient. Formerly, the physician said to the patient: "You are paralyzed, you have crises of sleep because you are willing to have these accidents." Now, it is recognized that he is not willing to have them, but it is still maintained that he thinks of them. "You have such or such a crisis with such or such an accident because you think of it." I say that this is not true: there are many hystericals who do not think of the accidents they have. First of all, with some patients, the accidents develop insidiously, unknown to them. They become anesthetic, paralytic, anorexic, amaurotic, without in the least suspecting it. Clinical practice shows you this every day. What shall we do, then, with the observations already cited by Lasegue, in which it is the physician who reveals to the subject an anesthesia, or the blindness of one eye, which he was not aware of. In other cases, it is incontestable that the accident develops with details, with an evolution that the patient does not know. Whatever M. Bernheim may say about it, I do not admit at all that hystericals have, at will, paralyses, with or without anesthesias. I do not admit that these patients know what happens in their somnambulisms, that they combine the disease beforehand.

If these patients have fixed ideas — and I acknowledge that this is very frequent — it should be well remarked that these fixed ideas have no relation to the medical form of their accident. One has the fixed idea of her mother's death; it is not at all the fixed idea of somnambulism and of its laws. Another has a fixed idea relative to the flight of his wife, who robbed him; it is not the fixed idea of dumbness. Much oftener than is believed, the accident develops independently of the ideas of the subject, whether the subject does not think of it or thinks of something else.

I should like to present, in the second place, an argument which is still weak, but the importance of which will grow more and more. It relates to the physiological and psychological laws of hysterical accidents, laws of which we are ignorant, and of which the subjects are ignorant like us. When we see a crowd of accidents evolve according to these laws, which we painfully describe, we cannot say that they are due to auto-suggestion.

I remind you of the laws of somnambulisms, which, in my opinion, are capital. Somnambulism is followed by an amnesia which bears not only on the abnormal period, but often also on the idea itself that fills it and on all the feelings connected with it. This amnesia disappears and all the apparently lost remembrances are restored when the subject comes back into the same somnambulism. In the case of Irene, which I take as a type, there is in the waking state an amnesia not only of the crisis, but also of her mother's death, of the three preceding months, and of all that is con-

nected with her affection for her mother, and during the fits all these remembrances are perfect. Do the subjects who show us applications of these laws — and, in my opinion, they are very numerous — do these subjects know them? Have they the idea of having such an oblivion in connection with their somnambulism? How very unlikely! They would much rather have the contrary idea, that of being obsessed by their remembrance like the psychasthenics.

The more hysterical paralyses are studied, the more laws of a similar kind will be discovered. I have observed to you that the accidents bear on functions. It is true that these functions oftenest appear to be identical with those which the vulgar have themselves recognized, the function of alimentation, the function of walk, the function of the movements of the hand. In this case, you will tell me, the paralysis might very well be brought about by an idea, since the popular idea coincides with the very limits of the paralysis. This is true in general, simply because the popular ideas are true. The great divisions of the functions correspond to the great divisions of the organs, and the popular analysis has been correct, that is all. But there are some cases in which the popular analysis proves ignorant and in which hysterical paralysis analyzes the functions much better than good sense does. Why are the disturbances of speech accompanied with right-sided hemiplegy? Why are there cases of hemianopsia? How is it that there are distinct paralyses of monocular vision and of binocular vision? Why are there disturbances of accommodation? If you pass on to con-

tractures, do you really believe that the patient has the idea of rigidity without fatigue, without increase of the temperature? That he has the idea of that modification of the reactions, of that slowness of the muscular shake? I am convinced, for my part, that hysterical contracture has its own laws, quite peculiar to it, presenting us, as I told you, a degradation of the contraction of the striated muscles. All this is outside of the thought of the subject. As I told you at the beginning, it will be, later, a matter of astonishment that physicians should have attributed to the caprice of the subject all the psychological and physiological laws that will be discovered in these various accidents.

Lastly, I insist on a third argument. These definitions have a meaning only on condition that the words "fixed idea" and "suggestion" are used in a particular sense. This sense should be that, with hystericals, ideas do not conduct themselves as with everybody. It is of no use for me to represent to myself that I am asleep; I do not, therefore, sleep. All these authors imply tacitly that these ideas act in a special manner on the mind and organism. I answer that it is this special action that is the essential point; it is this action that constitutes hysteria, and you have not the right to make a definition in which you tacitly imply what is essential. Begin by defining what you call suggestion, and afterwards you may say, if you choose and if it is true, that hysteria is a disease due to suggestion. But, to define suggestion, you will be obliged to introduce into your definition certain new notions which are precisely those I asked for.

IV

You will be obliged to recognize that these ideas present themselves in special conditions, that they develop out of measure because they meet with no counterpoise in the mind, because they are isolated, owing to a strange absent-mindedness of the subject; in a word, you will recognize the other stigmata, absent-mindedness and the retraction of the field of consciousness. When you have once admitted this retraction of the field of consciousness as one of the conditions of suggestion itself, why should you maintain that it can produce nothing but suggestions? Why should you not admit that this disease of the mind may be manifested by something else? If this retraction has given too much power to certain ideas, does it not produce, on the other hand, some blanks? Can it not isolate and emancipate one function and suppress another from consciousness?

We then arrive at another group of definitions in which I range mine. They are definitions, in my opinion, more profound, into which enter the phenomena of *dissociation of consciousness*, such as is observed in all hysterical disturbances. Suggestion itself is but a case of this dissociation of consciousness. There are many others beside the one in somnambulisms, in automatic words, in emotional attacks, in all the functional paralyses. Many authors, Gurney, Myers, Laurent, Breuer and Freud, Benedict, Oppenheim, Jolly, Pick, Morton Prince, have thought like me that a place should be made for the disposition to somnambulism. Was not the somnambulic attack for us the type of hysterical

accidents in 1889? "The disposition to this dissociation and, at the same time, the formation of states of consciousness, which we propose to collect under the name of hypnoid states, constitute the fundamental phenomenon of this neurosis," said MM. Breuer and Freud, of Vienna, in 1893.

The point which seems to me to be the most delicate in this definition is to indicate to what depth this dissociation reaches. In reality we might say that dementias themselves are dissociations of thought and of the motor functions. We must remember that, in hysteria, the functions do not dissolve entirely, that they continue to subsist emancipated with their systematization. What is dissolved is personality, the system of grouping of the different functions around the same personality. I maintain to this day that, if hysteria is a mental malady, it is not a mental malady like any other, impairing the social sentiments or destroying the constitution of ideas. It is a malady of the *personal synthesis*, and I will take up again, very slightly modified, the formula I have already presented. *Hysteria is a form of mental depression characterized by the retraction of the field of personal consciousness and a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality.*

V

Let us leave too general discussions and come back to a more clinical conception of things. The most important problem is not for me to understand what

hysteria in general is, but to account for the practical evolution of the accidents with such or such a person. The difficulty we meet with, then, is a difficulty of *localization*. How is it that with one person the hysteria bears on the arm, with another on the stomach, and that, with a third, it only reaches a system of ideas, which it turns into a somnambulism? It is on this search for an interpretation proper to each subject that one should dwell, to my mind, much more than on general quarrels of definition.

The starting-point of hysteria is the same as that of most great neuroses, it is *a depression, an exhaustion of the higher functions of the encephalon*. All the psychological operations do not present, as I repeat, the same difficulty. There are some operations that are easy for all kinds of reasons, first, because they are simple and only require the union of a small number of elements; second, because they are old, because their systematization was the work of our ancestors and is inscribed in strongly constituted organs. There are some other functions that are difficult because, on the one hand, they are very complex, because they necessitate the systematization of an infinite number of elements, and because, on the other hand, they are very new and require a present synthesis, not yet inscribed in the organism. Now, our nervous strength, which we do not know at all, presents oscillations. When it is high, we easily accomplish the operations of the second group, we have an extended consciousness, we turn back from no new study or action.

But there are many circumstances in which this

nervous tension is lowered, especially with those hereditarily predisposed. There are some physiological periods, puberty for instance, at which the vital forces seem to be busy elsewhere and to leave no great resource to the brain. There are diseases that, through a thousand mechanisms, through local lesions, through intoxication, through microbian infection, lower our nervous tension. Even in normal functioning, physical or intellectual fatigue is enough to produce momentarily the same result. Lastly, — the fact is more difficult to understand but incontestable, — emotion is characterized by this lowering of the nervous strength. Very likely, in emotion, there is a great expense of nervous strength necessitated by the new problem suddenly set, and the emotional disturbance must come close to that of fatigue. However it may be, our patients have been exhausted through one of the preceding causes. If hereditarily predisposed, they are enfeebled by puberty, or they succumb to intoxication, fatigue, or emotion. The diminution, the lowering of the nervous tension, may bring about a general lowering of all the functions, and especially of the highest. This is what takes place in the psychasthenic neuroses, in which the localization on a special point exists in a rather slight degree.

With hystericals, in consequence of particular dispositions, the lowering of the nervous strength produces, in some manner, a superficial retraction; there is, as it were, an autotomy. Consciousness, which is no longer able to perform too complex operations, gives up some of them. There is, it is true, a general en-

feeblement, which manifests itself through the common stigmata, but there is, above all, a localization of the mental insufficiency on such or such particular function. So we find again in hysteria the problem of localization, which is of great importance in this disease.

No doubt, in a certain number of cases, the localization is effected through suggestion. An idea suggested from without attracts the thinking in one direction or another, and brings about, besides, according to laws the subject does not know, such or such automatic functioning and such or such a loss of function.

This is only a particular case. The localization may also be effected through a process akin to suggestion, but which is not identical with it, according to the laws of psychological automatism. I have often drawn your attention to those individuals, who, having had an accident in certain circumstances and having been cured, always recommence the same accident each time they experience an emotion, though it has no relation with the first. The man who was wounded by a railroad engine has a delirium in which he sees an engine coming towards him. This is quite simple. Eleven years afterwards, he sees his wife die, and he recommences the engine delirium. Another has the tic of blowing through one of his nostrils because he had a scab in his nose, in consequence of a bleeding at the nose. He recovers from his tic, but he recommences it now, because he loses his fortune, because his child is ill, etc.

Third law: The dissociation simply bears on a function that, for some reason or other, has remained weak and disturbed. Many of our patients become

dumb after an emotion, but they were formerly inclined to stammer, their speech was quite insufficient. A girl's right leg becomes paralyzed; the reason is that, in her childhood, her right leg was affected with rachitis. In the case of another girl, the paralysis of a leg is due to the fact that, in her childhood, the leg was affected with a white tumour and remained long in bandage. This remark relates specially to the very numerous cases of associated hysteria: a disease of any kind bearing on viscera; often an organic lesion of the medulla or of the brain, enfeebles or disturbs some function and it is on this function that the hysteric emancipation is localized. So, in certain cases, hysteria makes conspicuous some light symptoms of organic diseases of the nervous system quite at their beginning by exaggerating them beyond all measure. The fact, for instance, was frequently observed in the cases of tabetic vomiting associated with hysteric vomiting.

Fourth law: The function that disappears is the most complicated and the most difficult for the subject. This law applies chiefly to professional and social paralyses.

Finally, *fifth law:* We remark a very curious fact, which we recognize without always being able to account for it. The dissociation bears on the function that was in full activity at the moment of a great emotion. There are here some physiological laws that cause the chief disturbance to bear on this function, that make it, probably through an association of ideas, through an evocation of the emotion, the most difficult for the subject.

It is the study of these laws, it is the search for these conditions, that constitute the important part of the study of hysteria. Leave the discussions of general definitions; they are premature discussions, which bear on purely verbal differences. Retain from these lessons the importance that attaches to the study of the psychological functions, the necessity of analyzing, in each particular case, the mental state of the patient.

If these lectures have inspired you with some interest for this kind of studies, if they can contribute to develop in your beautiful country the researches of pathological psychology, beside the researches of experimental psychology, so brilliantly represented, I think you will not have lost too much time in trying to understand a barbarous language.

For my part, I deeply feel your kind attention and reception, and I am proud of having had, for a few days, the honour of teaching you and of being the colleague of the masters of Harvard University.

INDEX

A

Abdomen, swelling of, among phenomena of respiration, 263–264.
Absent-mindedness, 172, 296, 309–311; rhythm of Cheyne-Stokes and, 254.
Abulia, 315.
Accommodation, spasm of, 206–207, 329.
Aerophagia, phenomenon of, 260.
Alimentation, hysterical disturbances of, 227 ff.; tics of, 264–269.
Allochiria, 183.
Alternation, stigma of, 302.
Amaurosis, unilateral, 168–169, 171, 188–195, 302.
Amnesia, retrograde, 37–43, 72; continuous, 72, 314; analysis of continuous, 72–74; the stigma of somnambulism, 124–125.
Amnesias, graphic method for representation of, 70–77.
Anesthesia, hysteric, in motor disturbances, 124–126; description of hysteric, 150–158; in paralyses, 150–158; difference between hysteric and organic, 162–163; change in, during intoxication of subjects of, 165; carried to high degree in unilateral amaurosis, 189; theory of anorexy through anesthesia of stomach, 236–238; respiratory, 246–247; stigma of, 272–276.
Anesthesias, mobility of, 163–164.
Anorexy, hysterical, 228–233; three periods of, 230; theories of, 233–234; motor agitations in, 239–241; suppression of feeling of fatigue in, 241–242; paralyses resulting from, 243–244.
Anosmia, hysterical, 249.
Apepsia hysterica, Gull's, 228.
Aphasia, 209; distinction between hysterical dumbness and, 215–217; motor, 218–219.
Aphonia, 217.
Asphyxia, hysterical, 247–248.
Aspiration, tics of, 266.
Astasia-abasia, 177–181, 217.
Astruc, 14.
Attention, incapacity of, 314.
Automatism, ambulatory, 44–45 (*see* Fugues); of writing, 212; verbal, 225.
Azam, Dr., case of double personality reported by, 78–82.

B

Babinski, on reflexes, 147, 148, 150; mentioned, 178, 279; definition of hysteria by, 325.
Ballet, 205, 219, 277.
Barks, hysterical, 262.
Bastian, Charlton, quoted, 175–176; work by, 322.
Bawl, the hysterical, 272.
Beauchamp, Miss, a case of complex personality, 85.
Benedict, 331.
Bernheim, 4, 17, 192, 193, 327; definition of hysteria by, 325.
Binet, 4.
Bladder, troubles of function of, 244.
Blindness, hysterical, 185 ff.; cases of, 186–187.
Bloch, apparatus devised by, 250.
Blocq, form of hysterical paralysis pointed out by, 177.
Blood, vomiting of, 268–269.
Borel, 186.
Bourru, 83.
Brachet, 15, 320.
Breuer, 4, 331, 332.
Brewster, experiment of, 192–193.

Briquet, 16, 151, 156, 167, 210, 255; quoted on hysteric fits, 102.
Brissaud, 4.
Bristow, 205.
Broca, 215.
Brodie, English physician, 15–16, 140, 176; work of, on local nervous affections, 131.
Bulimia, 264–265.
Burcq, 167, 236, 300; quoted on anesthesia and muscular weakness, 183.
Burot, 83.

C

Cartaz, on hysterical dumbness, 210, 214.
Catalepsy, form of somnambulism called, 33.
Chairon, 249.
Charcot, T. M., 3, 4, 12, 16–17, 20–21, 131, 140, 144, 151, 153, 161–162, 177, 198, 210, 233; quoted regarding fugues, 60; cases of double personalities of, 74; on motor agitations, 121, 122; helicopode and helcopode gaits of, 146, 174; case of hysterical dumbness studied by, 211; the anesthesia of, 273–276; definition of hysteria by, 324, 325.
Cheeks, spasms of, 265.
Cheyne-Stokes, rhythm of, 252–254.
Chorea of Sydenham, 123.
Choreas, rhythmical, 121–123.
Clonus of foot, 147; sign of, 149–150.
Consciousness, the field of, 303–304; contraction of field of, 304–311, 316, 332; dissociation of, 331–332.
Contraction of voluntary movements, 295–296.
Contractures, hysteric, 131 ff.; errors resulting from, in diagnoses, 132–133; causes and cure of, 133–135; miraculous cures and, 134; author's hypothesis concerning, 136–137; phenomenon of anesthesia in, 273–274.
Convulsive attacks, 94–104; analogy between somnambulisms and, 95–96; false theories concerning, 98–99; difference between epileptic fits and, 100, 110; distinguishing characteristics of, 100–104.
Coprolalia, 225.
Coriat, H., paper by, 55.
Corson, Mrs. C. Rollin, 303.
Coste, works of, 249.
Cough, the hysterical, 260–261.
Coulson, 131.
Courtney, Dr. J. M., paper by, cited, 58–59.

D

Dana, Dr., cited, 66.
Danilewsky, works of, 249.
Deafness, hysterical, 183–184.
Dejerine, observations of functional hemianopsia by, 200.
Delbœuf, 4.
Despine, Dr. (d'Aix), 139–140, 236.
Devil's claws, 151, 272–273.
Diaphragm, paralysis of, 254–257.
Digestion, hysterical disturbances of, 227 ff.
Diplopy, monocular, 207.
Dipsomania, polydipsia distinguished from, 265.
"Diseases of Memory," Ribot's, 78.
Dissociation of consciousness, 331–332.
"Dissociation of a Personality," Prince's, 67.
Double personalities, 66 ff.; rarity of cases of, 67; the first type of, the Lady of MacNish, 68–69; and reciprocal somnambulisms, 72–77; the dominating somnambulism in, 77 ff.; case of Felida X., 78–81; the group of complex cases, 83–86; case of Marceline, an artificial double personality, 86–91; oscillation of mental activity in, 92.
Drinking, mania for, 265.
Dubois, Dr., 323.
Duchenne (de Boulogne), 15, 140.
Duchesne, Marguerite Françoise, case of, 210.
Dumbness, hysterical, 209–215.
Dumontpallier, 282, 300.
Dutil, 165.
Dyschromatopsia, 204.

E

Eating, mania for, 264–265.
Echolalia, 225.
Electricity, action of, on sensibility, 167; power of speech restored by, 210.
Emotional disturbances, 314.
Equivalences, 298, 301–302.
Eructation, tics of, 266.
Eyes, disturbances in motion of the, 205–207. *See* Vision.

F

Falsehood in hysteria, 278–279.
Fancher, "Mollie," double personalities of, 84–85.
Felida X., story of double personality of, 78–81.
Fere, Dr., 4, 6; observations of, on hysterical paralyses, 141–142; quoted on hysterical paralyses, 175.
Fits, hysteric, 94 ff.; false theories about, 98–99; difference between epileptic and, 100, 110; characteristics of, 100–104.
Fixed idea, theory of, in anorexies, 234–235; importance of, in certain hysterical accidents, 324–325; have no relation to the medical form of the accident, 328.
Flees, Dr., box of, for eye-testing, 190–192.
Flights. *See* Fugues.
Flourens, 249.
Forel, 4.
Français, Henry, 239.
Franck, works of, 249.
Freud, Professor, 4, 145, 331, 332.
Fugues, hysterical, 44–45; examples of, 45–61; analogy between monoideic somnambulisms and, 54–59; differences between somnambulisms and, 59–61; artificial reproduction of, 112.

G

Gelle, 220.
Georget, 15, 151.
Goodhart, "Multiple Personality" by, 67.
Grasset, 4, 324.
Gull, W., anorexy described by, 228.
Gurney, 331.

H

Hallion, study of vascular reflexes by, 160.
Hallucinations, connected with somnambulisms, 32–37, 59–60; lacking in fugues, 60.
Harris, Wilfred, on hysterical hemianopsia, 200–201.
Hauron, Ducos de, 194.
Helicopode and helcopode gaits, 146, 174.
Hemianesthesia, 153–154.
Hemianopsia, hysterical, 199, 329; compared with hysterical hemiplegy, 200–201.
Hemiplegy, 142–143; organic and hysteric, 146–147; hysterical hemianopsia compared with, 200–201; a case of hysterical, 212.
Hiccough, the hysterical, 259–260.
Huchard, 176.
Hufeland, 15.
Hypnogenic points, 108–109, 113.
Hypnotism, case of double personality treated by means of, 86–89; artificial somnambulisms called, 114; question concerning hysteric somnambulism and, 114–116.
Hysteria, evolution of studies about, 13 ff.; derivation of the word, 15; notice of Charcot's work in, 16–17; the psychological type of, 18–20; somnambulism the typical form of accidents of, 22–24; study of the stigmata of, 270 ff.; suggestibility the most important stigma of, 285–292; other stigmata of, 293 ff.; resume of typical symptoms of, 317–321; various definitions of, 321–326; discussion of definitions, 326–332; author's formula of, 332.
Hysterogenic points, 98–99, 113.

I

Idea. *See* Fixed idea.
Inanition, hysterical, 228–229; period of, in hysterical anorexy, 232.
Incapacity, of attention, 314; of beginning and stopping, 315.
Incompleteness, the feelings of, 312–313.
Ingenieros, Jose, book by, 322.
Insensibility, phenomena of, in tics, 124–125; examination of, in paralyses, 150–158; vanishing of, during intoxication, 165.
Insomnia, 315.
Inspiration tics, 259.
"Intelligence," Taine's, 78.
Intestine, paralysis of, in disturbances of alimentation, 243–244.
Intoxication and anesthesia, 165.

J

Jaccoud, form of hysterical paralysis pointed out by, 177.
James, William, cited, 175.
Janet, Jules, 162, 165.
Jaws, spasms of, 265.
Jolly, F., 188, 331.

K

Kaempfen, case of retrograde amnesia of, 71.
Kissel, case of anorexy cited by, 229.
Koenig, case of ophthalmoplegy of, 205.
Kussmaul, 210.
Kuttner, patient of, with vomiting of blood, 268.

L

"Lady of MacNish," story of, 68–69; analysis of case, 72–77; a type of so-called "reciprocal somnambulism," 74.
Landolt, 186.
Landouzy, 15, 151.
Lapses of the mental functions, 313–316.
Lasegue, 131, 161, 168, 171–172, 233, 320, 327; anorexy described by, 228.
Laughter, hysterical, 261.
Laurent, 331.
Laziness, hysterical state of, 314.
Lebreton, 205.
"Leçons du Mardi," Charcot's, 219.
Lepine, 219, 249.
Lepois, Charles, 14, 185–186.
Lermoyez, M., 246–247.
Limbs, disturbances in motor functions of, 117–119.
Localization, the laws of, 333–337.
Lowering of the mental level, the, 316.

M

Mabille, case of Louis Vivet published by, 83.
MacNish, Dr., 67, 68.
Macropsia, 207.
Malebranche, 291.
Marceline, the case of, 87–91.
Marie, Dr. Pierre, 4, 209.
Marion, Elie, case of, 225.
Mathieu, A., 267, 268, 325.
Memory, loss of, connected with somnambulism, 37–43; absence of, 314.
"Mental State of Hystericals," Janet's, 303.
Merycism, 266.
Mesnet, 4.
Meteorism of the abdomen, 263–264.
Micropsia, 207.
Miracles, performance of religious, accounted for, 134.
"Miracles of Deacon Paris," Montgeron's, 134, 210.
Mitchell, S. Weir, 67; case of double personality of, 74–77.
Mœbius, 4, 277; definition of hysteria by, 325.
Monoplegy, 144.
Montgeron, Carre de, 134, 210.
Morax, 206.
Mosso, 249, 254.

Motor disturbances of limbs, 117–119.
"Multiple Personality," Sidis and Goodhart's, 67.
Münsterberg, Professor, 3.
Mutism, hysterical, 209–215.
Myers, Arthur, 84, 331.

N

Narrowing of the visual field, 195–201.
Neuroses, traumatic, study of, 140.

O

Œsophagus, spasms of the, 243–244, 266.
Ophthalmoplegy, 205–206.
Oppenheim, 140, 224, 331; definition of hysteria by, 325.

P

Pachon, works of, 249.
Page, W., 176.
Paget, 131.
Paralyses, hysteric, 138–139; causes of, 140–142; varieties of (hemiplegy, paraplegy, monoplegy, paralyses of the trunk), 142–144; diagnosis of, 145–150; difference between organic paralyses and, 146; systematic, 178; of digestive organs in disturbances of alimentation, 243–244; respiratory, 246 ff.; of the diaphragm, 254–257; phenomenon of anesthesia in, 273–274.
Paraplegy, 143.
Pare, Ambroise, 14.
Parinaud, 186, 192, 193, 206, 207.
Pawlof, 237.
Personalities, double. *See* Double personalities.
Pharynx, spasms of the, 265.
"Philosophy of Sleep," MacNish's, 68.
Photophobia, 205.
Pick, A., 295–296, 331.
Pitres, 4.
Polydipsia, 265.
Polyopy, 207.
Polypnœa, respiration in cases of, 255–256, 257–258.
Polyuria, 265.
Pomme, 14.
Prince, Morton, 4, 331; cited concerning double personalities, 67; observations of Miss Beauchamp, 85.
Ptyalism, 266.

R

Railway spine, 140.
Ramadier, 83.
Recruits, eye tests for, 189–192.
Reflexes, 147; cutaneous, 148; signs of, 149; pupillary, 150, 189; absence of modification of, 160–162.
Regnard, 192.
Regurgitation, 266.
Reproduction of hysteric accidents, 110–115.
Respiration, tics of, 245 ff.; paralysis of, 246 ff.; alternating see-saw, 255.
Retraction of field of consciousness, 304–311, 316, 332.
Revery, hysterical state of, 314.
Revillod, 210.
Reynolds, Mary, case of double personality, 74–77.
Reynolds, Russell, 140.
Rhythm of Cheyne-Stokes, 252–254.
Ribot, Professor, 3, 4; on double personality, 78.
Richer, Paul, 4, 131.
Richet, Charles, 4, 249, 277.
Robertson, Argyll, 150.
Roux, J. C., 267, 268, 325.

S

Salivation, tics of, 265.
Salute, the, in motor agitations, 121.
Saulle, Legrand du, 15, 83, 277, 279.

Sauvage, 14.
Seglas, 177, 225.
Sensibility, disturbances of, 249–251.
Sensitiveness, modifications of, during induced somnambulisms, 166–167.
Sidis, B., "Multiple Personality" by, 67.
Sigh, the hysterical, 259.
Simulation, perpetual, so-called, 277 278.
Sitieirgia, 229.
Sitiophobia, 229.
Sleep, fits of, examined as an accident of hysteria, 104–109.
Smell, disturbances of sense of, 183.
Snellen, letters of, for eye-testing, 190.
Sollier, 219, 236.
Somnambulisms, definition of, 24; illustrative cases of monoideic, 26–32; characteristics of, 32–37; analogy between fugues and, 54–59; differences between fugues and, 59–61; polyideic, 61; illustrative cases, 61–64; emancipation of feelings and emotions in, 64–65; reciprocal, 72–74; cases of, 74–77; dominating, 77, 81–82; complex (double and reciprocal), 83; analogy between convulsive attacks and, 95–96; connection between fits of sleep and, 104–109; artificial, or hypnotism, 110–115.
Spasms of jaws, cheeks, and of pharynx, 265.
Speech, troubles of, 208 ff.; tics of, 224–225; automatic, 225; emancipation of function of, 226.
Spitting, tics of, 265.
Stammering, 217.
Stigmata, problem of, 271 ff.; division into proper and common, 294; the common, 311–312.
Strabismus, 206.
Strumpell, definition of hysteria by, 325.
Subconsciousness, phenomenon of, 296–297.
Suggestibility, 270 ff.; the most important mental stigma of hysteria, 292.
Suggestion, mental phenomenon of, 279 ff.; distinct meaning of, 279, 330; description of principal facts of, 279–281; difference between normal phenomena and, 283–285; the conditions of, 285–286.
Swelling of abdomen, 263–264.
Sydenham, 14, 18, 151, 271; chorea of, 123.

T

Taine, on double personality, 78.
Tardieu, 277.
Taste, disturbances of sense of, 183.
Tics, 119–123; characteristics of, 123–128; hysteric anesthesia in, 124–126; of speech, 224–225; of inspiration, 259; expiratory, 260–264; complex phenomena of, 262–264; of perpetual spitting and salivation, 265; of eructation, 266.
Todd, study of traumatic neuroses by, 140.
Touch, disturbances of sense of, 182 183.
Tourette, Gilles de la, 4, 199, 224, 237; work of, cited, 248.
Tours, Moreau de, 7.
Transfers, 298–300.
Tremors, phenomenon of, in hysteria, 129–131.

U

Unity, need of, under diversity of hysterical phenomena, 270–272.

V

Vascular reflexes, 160.
Villermay, Louyer de, 15, 151.
Vision, troubles of, 185 ff., 329; dissociation of monocular and binocular, 193–195; narrowing of the visual field, 195–201; disturbances in movements of the eyes, 205–207.

Vivet, Louis, case illustrating complex somnambulisms, 83–84.
Voice, troubles with. *See* Speech.
Voisin, Jules, 83, 165.
Vomiting, hysterical, 266–268, 301, 325, 336; of blood, 268–269.

W

Walks, helicopode and helcopode, 146, 174.
Wallet, Dr., article by, 239–240, 241.
Walton, Dr. G. L., 184.
Watson, English surgeon, 210.
Will, disturbances of the, 314–315.
Witt, 14.
Word-blindness, 219.
Word-deafness, 219–221.

Y

Yawn, the hysterical, 259.

THE

Common Bacterial Infections

OF THE

Digestive Tract

AND THE INTOXICATIONS ARISING FROM THEM

By C. A. HERTER, M.D., Professor of Pharmacology and Therapeutics in Columbia University; Consulting Physician to the City Hospital, New York.

Cloth, 8vo, 360 pages, $1.50 net; by mail, $1.63

"The methods of investigating the digestive tract outlined in this volume will prove valuable to the practitioner who would determine the presence of abnormal bacterial processes before the onset of the clinical signs of incurable or highly refractory states of intoxication — and this is the all-sufficient raison d'etre for the book. Considerable stress has been laid by the author on methods developed in his laboratory, in the belief that their painstaking application will furnish practitioners with reliable indications as to the progress of many cases of infection of the digestive tract." — *Merck's Archives.*

"A very scholarly volume, primarily intended for physicians and students, yet, because of its grave importance and because the subject it treats of is of vital interest to all intelligent readers, we are quite certain the book will be appreciated and read in a far wider circle than its title, which is rather 'professional sounding,' might warrant. We call the reader's attention especially to the last chapter in the book, in which there is expounded much valuable material of common interest." — *Times.*

THE MACMILLAN COMPANY

64 66 FIFTH AVENUE, NEW YORK

A NEW EDITION, REVISED
THROUGHOUT WITH ADDITIONS

A System of Medicine

English and American, in Nine Volumes

EDITED BY

THOMAS CLIFFORD ALLBUTT
University of Cambridge

and **H. D. ROLLESTON**
Physician to St. George's Hospital,
the Victoria Hospital for Children, etc.

And Two Hundred Eminent Authorities as Contributors

With Plates, Charts, Tables, and Diagrams

Price of the set: in cloth, $45 net; in sheep, $54 net; half morocco, $63 net; sold on orders for sets only

---

A System of Gynæcology

In One Volume. Edited by

THOMAS CLIFFORD ALLBUTT
W. S. PLAYFAIR, and T. W. EDEN

Uniform with the Allbutt and Rolleston System of Medicine, but sold separately if desired

Cloth, $5 net; sheep, $6 net; half morocco, $7 net

"We feel that by this time praise of the work is unnecessary. When the first volume appeared we praised it without stint, expressing the hope at the same time that the other volumes would be up to the standard of the first. The hope has been realized, for the work has shown the rare merit of evenness throughout. . . . The opinion oftenest expressed is in accord with our own; namely, that the work is by all odds the best presentation of the science and the art of medicine in the English language." — *New York Medical Journal.*

THE MACMILLAN COMPANY
64 66 FIFTH AVENUE, NEW YORK

Some Points in the Surgery of the Brain and Its Membranes

By **CHARLES A. BALLANCE**, M.V.O., M.S., F.R.C.S., Royal Prussian Order of the Crown; Corresponding Member of the Society of Surgery of Paris; Surgeon to St. Thomas's Hospital and to the National Hospital for the Paralyzed and Epileptic; President of the Medical Society of London, etc.

Cloth, 8vo, with over 200 illustrations, $5.00 net

Epilepsy, a Study of the Idiopathic Disease

By **WILLIAM ALDREN TURNER**, M.D., Edin.; Fellow of the Royal College of Physicians of London; Physician to Out Patients, the National Hospital for the Paralyzed and Epileptic, Queen Square and King's College Hospital, London, etc.

Cloth, leather back, gilt top, 8vo, 272 pp., $3.25 net

Studies in Clinical Psychiatry

By **LEWIS C. BRUCE**, M.D., F.R.C.P.E.

"When psychology is divorced from psychiatry and the latter study is prosecuted along the lines of advance in general medicine, our knowledge of mental diseases cannot fail to be added to. The matter contained in this book is based on work so conducted; psychology is omitted; pathology, in so far as the changes in the brain cells and nerve fibres are concerned, is practically ignored, because, until we know what the causes of such changes are, we are none the wiser for the knowledge."

Cloth, 8vo, 246 pages, $4.00 net

Clinical Psychiatry

A Text-book for Students and Physicians, abstracted and adapted from the German of Kraepelin's "Lehrbuch der Psychiatrie"

By **A. ROSS DIEFENDORF**, M.D., Lecturer in Psychiatry, Yale University.

Cloth, 8vo. New edition in June, 1907

Inflammation An Introduction to the Study of Pathology

By J. GEORGE ADAMI, M.D. A revised and enlarged reprint of an article in Allbutt's "System of Medicine," by Dr. Adami, who is a Professor of Pathology in McGill University, Montreal.

Cloth, gilt top, 8vo, xvi + 240 pp., index, illus., $1.60

The author believes that a knowledge of the inflammatory process is the foundation of all pathology, and has here brought together all the data known to him bearing upon the subject, including some very recent, such as a description of Sir A. E. Wright's brilliant researches upon opsonins, and Professor Bier's treatment of inflammation by induced hyperæmia.

Eye Injuries and Their Treatment

By A. MAITLAND RAMSAY, M.D., Faculty of Physicians and Surgeons, Glasgow; Ophthalmic Surgeon, Glasgow Royal Infirmary; Professor of Ophthalmology, St. Mungo's College; Lecturer on Eye Diseases, Queen Margaret College, University of Glasgow; Author of "Atlas of External Diseases of the Eye," etc.

With many plates in color. Cloth, large 8vo, $6.00 net

The work is thoroughly practical (clinical), deals largely with treatment, and contains general directions for operating on the eye, a chapter on ocular therapeutics, and many pages of formulæ. The plates are excellent examples of color lithography and photogravuring.

Studies in the Bacteriology and Etiology of the Oriental Plague

By E. KLEIN, M.D., F.S.S., Lecturer on Advanced Bacteriology in the Medical School of St. Bartholomew's Hospital, London. With 89 photograms.

Cloth, 8vo, xv + 301 pp., $4.00 net

Anæsthetics and their Administration

A Text-book for Medical and Dental Practitioners and Students

By FREDERICK W. HEWITT, Physician-Anæsthetist to St. George's Hospital; Consulting Anæsthetist and Emeritus Lecturer on Anæsthetics at the London Hospital.

Third edition, with illustrations. Cloth, $4.00 net

PUBLISHED BY

THE MACMILLAN COMPANY

64-66 FIFTH AVENUE, NEW YORK

Made in the USA
San Bernardino, CA
02 October 2017

Digitally Remastered

Forgotten Books

Forgotten Books' Classic Reprint Series utilizes the latest technology to regenerate facsimiles of historically important writings.

Careful attention has been made to accurately preserve the original format of each page whilst digitally enhancing the quality of the aged text.

Philosophy ~ Classics ~ Science ~ Religion
History ~ Folklore ~ Mythology

Forgotten Books

For more publications by Forgotten Books visit www.forgottenbooks.org